

Toolkit

Nursing Home Closures Toolkit for Ombudsmen and Advocates



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The National
CONSUMER VOICE
for Quality Long-Term Care

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NATIONAL CONSUMER VOICE FOR QUALITY LONG-TERM CARE
theconsumervoice.org

The Consumer Voice is the leading national voice representing consumers in issues related to long-term care, helping to ensure that consumers are empowered to advocate for themselves. We are a primary source of information and tools for consumers, families, caregivers, advocates and ombudsmen to help ensure quality care for the individual.

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Please send any questions or comments to info@theconsumervoice.org.

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INTRODUCTION

This toolkit includes material that will be helpful to you if you are involved in a nursing home closing.

Section 1 is the PowerPoint used in training ombudsmen and other state officials about nursing home closures.

Section 2 is the Executive Summary from the National Consumer Voice's for Quality Long-Term Care report *Successful Transitions: Reducing the Negative Impact of Nursing Home Closures*. For entire study, see http://theconsumervoice.org/uploads/files/issues/CV_Closure_Report_-_FINAL_FINAL_FULL_APPENDIX.PDF.

Section 3 are the State Case Studies from the National Consumer Voice's for Quality Long-Term Care report *Successful Transitions: Reducing the Negative Impact of Nursing Home Closures*. For entire study, see http://theconsumervoice.org/uploads/files/issues/CV_Closure_Report_-_FINAL_FINAL_FULL_APPENDIX.PDF.

Section 4, *Federal & Sample State Guidelines on Closures*, describes the Centers for Medicare and Medicaid (CMS) guidelines for closure. There are also descriptions of the requirements in three states with some unique features as well as an actual closing plan.

Section 5, *Sample Letters to Residents & Families*, might be of help as you develop your own material.

Section 6, *Sample Forms & Checklists*, has several forms and checklists used by many different states as they monitor closures.

Section 7, *Additional Consumer Voice Resources*, includes a brochure and information card for residents & family members about knowing their rights during a nursing home closure.

NOTE: Some state materials have been edited for the purposes of formatting into this toolkit. The content remains unchanged.

SECTION 1

TRAINING POWERPOINT

Training: Nursing Home Closures

SUPPORTED WITH A GRANT FROM RETIREMENT RESEARCH FOUNDATION

THE NATIONAL CONSUMER VOICE FOR QUALITY LONG TERM CARE

CYNTHIA RUDDER, PHD

Day One: MORNING AGENDA

- Your experiences with closures
- Review Of National Study Funded By The Retirement Research Foundation
 - Objectives and Results
 - State Best Practices
 - Recommendations
- New Federal Requirements when Discharging a Resident
- Federal Rules on Closures

FIRST DAY: 9:15 TO 9:30

YOUR EXPERIENCES WITH CLOSURES

Why did you apply for this training?

What are some of the issues you have faced?

Did you find any differences between voluntary and involuntary closures?

Did you find any obstacles to a successful transition for residents?

If yes, what were they?



FIRST DAY: 9:30 TO 10:30

NATIONAL STUDY FUNDED BY THE RETIREMENT RESEARCH FOUNDATION

Using online surveys and one-on-one interviews:

OBJECTIVES:

Identify obstacles

Identify policies and procedures for overcoming the obstacles

Identify best practices

Make recommendations



OBSTACLES TO A SUCCESSFUL CLOSING

Lack Of Appropriate And Nearby Placements

Poor Discharge Planning

Lack Of Communication

Poor Notice/Not Enough Time

Staffing Issues

Transfer Trauma

STATE BEST PRACTICE CASE STUDIES

OHIO

WISCONSIN

CONNECTICUT

BEST PRACTICES

One of the most important best practice was the development of a “relocation team;” all agencies work together.

Meeting one-on-one with residents and families.

Follow up of transitioned residents.

Focusing on transfer trauma.

Focus on needs of staff as well as residents.

Focus on receiving facility as well as closing facility.

Laws permitting state to deny voluntary closure.

Laws facilitating residents’ choice of where to be transferred.



WISCONSIN



- Under Wisconsin statute, whenever a facility wants to move 5 or more residents, a **relocation specialist** from the State Ombudsman Office oversees the transition: downsizing, closure or renovation, etc.
- The relocation plan which is submitted to the state must include ways the closing facility will **mitigate transfer trauma**.
- “Lessons-learned” meetings.
- Focus on the needs of staff as well as residents.

WISCONSIN: 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.

**Resident Relocation Planning and Procedure Manual Department of Health Services Division of Long Term Care November 2010.

WISCONSIN: RECOMMENDATIONS FOR ENHANCING THE RESIDENT RELOCATION PROCESS

- Tailoring activities to address the changing environment
 - arranging to tour examples of various residential options
 - holding “going away” parties
 - shopping for things needed in a new setting such as household goods
 - arranging “drive-bys” past new living arrangements to help residents become oriented to new and unfamiliar locations.

WISCONSIN: RECOMMENDATIONS FOR ENHANCING THE RESIDENT RELOCATION PROCESS

- 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.

WISCONSIN: RECOMMENDATIONS FOR ENHANCING THE RESIDENT RELOCATION PROCESS

- 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.

WISCONSIN: GUIDE FOR 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.
- Know that a resident who is relocating may be experiencing emotional and physical symptoms related to relocation stress syndrome/transfer trauma.
- Facilitate a caregiver visiting the resident in the closing facility in an effort to ease the resident's transition to their new home.

WISCONSIN: GUIDE FOR RECEIVING FACILITY

- Facilitate a resident tour of the facility/living setting before the actual day of the relocation.
- Designate a primary facility contact for the resident/family/legal representative to keep in contact with throughout the relocation process and after the actual relocation.
- Provide names and contact information to resident/family/legal representative for key staff in the receiving facility.

WISCONSIN: GUIDE FOR RECEIVING FACILITY

- Assure nursing staff and other interdisciplinary team members/service providers review transfer information (physician's orders, medical history, social history, etc.) and complete admission assessments. The team needs to assess the resident's risk for relocation stress syndrome/transfer trauma.
- Include the resident/family/legal representative's input in the assessment process.
- Seek out resident information regarding likes, dislikes, preferred daily routines, etc. and ensure the information becomes part of the direct care givers' care plan. .

WISCONSIN: GUIDE FOR RECEIVING FACILITY

- Implement admission care plan addressing potential risk for transfer trauma/relocation stress syndrome and interventions to minimize risks.
- Document resident's reactions and concerns upon arrival.



WISCONSIN: GUIDE FOR RECEIVING FACILITY

- Be alert for and put interventions in place to address safety risks such as weight loss, falls, anxiety, and confusion that could result from being in an unfamiliar environment.
- Provide a warm, friendly environment and encourage family/legal representative to stay while the resident is getting settled in his/her new living setting/home.
- Review the personal belongings inventory, from the closing facility, and verify the presence of all belongings and any funds.

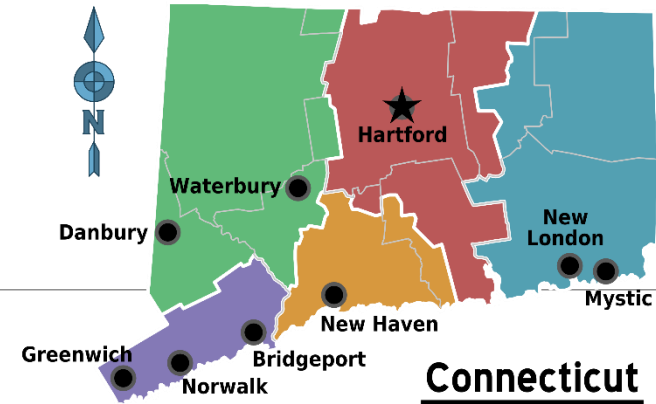
WISCONSIN: GUIDE FOR RECEIVING FACILITY

- Assist resident to unpack and organize belongings with resident input.
- Introduce new resident to the other residents, volunteers, staff, and families as the resident is willing.
- Establish routines for the resident with resident and family/guardian input and with information shared from the closing facility.
- Assign a primary nurse or caregiver to assess the resident frequently and to monitor for signs of transfer trauma/relocation stress syndrome and implement necessary interventions.

WISCONSIN: GUIDE FOR RECEIVING FACILITY

- Assign a consistent caregiver(s) for at least the first 30 days to assist the resident with transition to their new environment.
- If indicated, encourage attendance and participation at resident and family council meetings.

CONNECTICUT

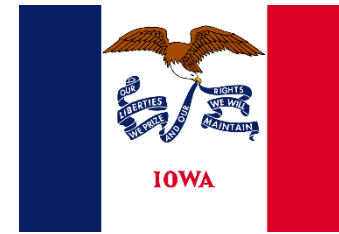


- State can deny voluntary closure.
- Requirement that state ombudsman notices residents/families at same time as facility.
- Laws permitting a waiver of a waiting list for residents coming from a closed facility.
- Laws permitting a resident to temporarily be admitted to a facility until a first choice is available.

OTHER IDEAS



IOWA



- DIA (Department of Inspections and Appeals) **monitors staffing levels** during the closure process.

 - If staff members are quitting, the team requests the facility obtain temporary staffing for the closure.
- Iowa also has a unique practice of employing a **discharge specialist** to handle involuntary discharge/transfer notices.
 - In one-on-one meetings, the discharge specialist assists residents and their decision-makers with how the closure will impact them.
 - 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.
- Uses CMP funds.

MICHIGAN



- Developed a complete guide to closure*
- Their closure team 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.
- 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.

*Best Practices for Regulatory Nursing Facility Closure.”

RHODE ISLAND



-
- 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.



SOUTH CAROLINA

- To ensure that residents have at least 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.

WASHINGTON, DC



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

WASHINGTON, DC



- Washington DC's Code gives private right of action 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 enjoin a facility from violating any provision of the law. It also gives them the right of civil action for damages.
- This Code also 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.

BREAK 10:30 to 10:45



FIRST DAY : 10:45 to 11:30

RECOMMENDATIONS: CMS - GENERAL

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, 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.

RECOMMENDATIONS: CMS - GENERAL

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.



RECOMMENDATIONS: CMS – RELATED TO OBSTACLES

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 find a solution to the problem.



RECOMMENDATIONS: CMS – RELATED TO OBSTACLES

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.



RECOMMENDATIONS: CMS – RELATED TO OBSTACLES

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.

RECOMMENDATIONS: CMS – RELATED TO OBSTACLES

Require a state to: 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; make improvements based on analysis; and submit complaint review/analysis to CMS.

Require states to develop a closure manual for providers which include checklists of tasks they must carry out before any resident is transferred.

Require on-site monitoring of the closing facility by the relocation team described above.

RECOMMENDATIONS: CMS – RELATED TO OBSTACLES

Require the regulatory agency to cite and fine a facility for giving inaccurate information.

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 their timeliness of surveys.

Require providers do all the tasks listed as guidance in the interpretive guidelines.

PENALTY!

RECOMMENDATIONS: CMS – RELATED TO OBSTACLES

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, or the owner runs out of funds, the state must be prepared to impose a receiver to manage facility operations.

RECOMMENDATIONS: CMS – RELATED TO OBSTACLES



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 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 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.

RECOMMENDATIONS: CMS – RELATED TO OBSTACLES

Require the state relocation team to focus on the needs of staff by notifying the state to help with unemployment insurance and finding a new position.

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 and how it may help staff find new employment.



RECOMMENDATIONS: CMS – RELATED TO OBSTACLES

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.

Require the state to hire additional outside staff if necessary, paid for by the closing facility.

Require that the facility closure plan submitted to the state include ways in which the closing facility will attempt to lessen any transfer trauma.

Require both closing and receiving facility to undertake specific tasks to lessen transfer trauma.

RECOMMENDATIONS FOR STATE AGENCIES: GENERAL

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.

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.



RECOMMENDATIONS FOR STATE AGENCIES: GENERAL

Pass legislation to codify the state closure process, including provider requirements, residents' rights; and relocation team tasks.

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; make improvements based on analysis; and submit complaint review/analysis to CMS.

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.

RECOMMENDATIONS FOR STATE AGENCIES: GENERAL

Require a public hearing before a facility can voluntarily close.



RECOMMENDATIONS FOR STATES: SPECIFIC

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.

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 and the contact information to make any complaints.

RECOMMENDATIONS FOR STATES: SPECIFIC

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.

RECOMMENDATIONS FOR STATES: SPECIFIC

Require that the relocation team meet regularly with and provide written updates to residents and families.

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.

Ensure continued Medicare and/or Medicaid payments until residents are successfully relocated.

Require the closing facility to report staffing on each shift each day to make sure they have adequate staff to care for the residents .

RECOMMENDATIONS FOR STATES: SPECIFIC

Require the closing facility to hire contract staff if needed.

Notify the state Department of Labor agency to help staff with filing for unemployment, writing resumes, etc. See case studies for ideas.

Consider a tax on ownership licenses to fund a staffing account that might give bonuses to staff that remain until closure.

Encourage facilities to hold job fairs for staff of closing facilities.

Require all facilities to train staff on transfer trauma.

Require the receiving facility to develop a plan to minimize transfer trauma for residents being admitted from the closing facility.

RECOMMENDATIONS FOR OMBUDSMEN: GENERAL

Educate all ombudsman program representatives on state and federal closure rules

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 FOR OMBUDSMEN: SPECIFIC

Check records of those residents being refused admittance to make sure they are up-to-date.

Urge refusing facilities to interview and assess the resident themselves to see if they might change their mind.

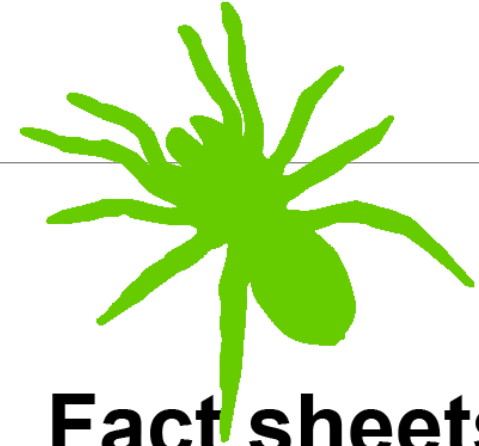
File a discrimination complaint with the Civil Rights Division of the U.S. Department of Health and Human Services and/or your state civil rights division if applicable if you feel that a resident is being discriminated against on the basis of his/her disability.



RECOMMENDATIONS FOR OMBUDSMEN: SPECIFIC

Create fact sheets detailing:

- What appropriate discharge planning includes.
- Residents' rights throughout the closure process.
- Where to file a complaint or get help.
- Information on how families can help prevent or minimize transfer trauma in residents.
- 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.



Fact sheets

RECOMMENDATIONS FOR OMBUDSMEN: SPECIFIC



Designate a member of the State Ombudsman Office as a relocation specialist

Develop a letter to be handed to all 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.

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.

RECOMMENDATIONS FOR OMBUDSMEN: SPECIFIC

Advocate for facility to remain open until all residents have been relocated.

Urge the passage of legislation permitting long-term care ombudsmen to file a request for receivership.

Advocate with corporation of closing facility for staff to be hired at sister facilities.

Advocate with nursing home administration to provide staff with a list of employment resources.

RECOMMENDATIONS FOR OMBUDSMEN: SPECIFIC

Develop in-service training for staff on transfer trauma with input from residents.

Create a list of tips for what staff and family can do to help alleviate transfer trauma.

Conduct follow-up visits after the relocation to see how residents are doing and provide continuity to residents.

Track residents' belongings to ensure they are moved to the new location with the resident.

FIRST DAY: 11:30 TO 12 NOON

NEW FEDERAL RULES ON DISCHARGE*

When the facility transfers or discharges a resident the facility must ensure that the transfer or discharge is documented in the resident's medical record **and appropriate information is communicated to the receiving health care institution or provider.**

Documentation must include:

- Reason for the transfer
- If facility states that the resident's needs cannot be met, it state what needs can't be met, how it attempted to meet the needs and the service available at the receiving facility that will meet the needs
- Documentation must be made by the resident's physician

*section 483.15(c)(2) and section 483.15(c)(7) & (8)



NEW FEDERAL RULES ON DISCHARGE

Information provided to receiving facility

- Contact information on practitioner responsible for the resident
- Resident representative information
- Advanced Directive information
- Special instructions for ongoing care
- Comprehensive care plan goals

NEW FEDERAL RULES ON DISCHARGE: NOTIFICATION

- Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. **The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.**
- Contents of the Notice Must Include:
 - The reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged
 - **A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request**

NEW FEDERAL DISCHARGE RULES: ORIENTATION

Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. **This orientation must be provided in a form and manner that the resident can understand.**

FEDERAL RULES



Rules

Timing

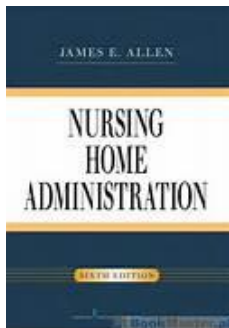
- For **voluntary or State-mandated closures**, the required written notification must not be later than **60 days prior** to the date of such closure.
- If the Secretary terminates the facility's participation under this title (involuntary), notification must be provided **no later than the date that the Secretary determines appropriate**.

FEDERAL RULES ON CLOSURES



Administrator Duties

- Administrator of the facility must submit to the State Survey Agency, the State LTC ombudsman, residents of the facility, and the legal representatives of such residents or other responsible parties, written notification of an impending facility closure.
- The administrator must also ensure that the facility does not admit any new residents on or after the date on which such written notification is submitted.



FEDERAL RULES

- The facility will not close until all residents are transferred in a safe and orderly manner to the most appropriate setting in terms of quality, services, and location, as available and determined appropriate by the resident's interdisciplinary team after taking into consideration the resident's individual needs, choices, and interests;
- Each resident's complete medical record information including archived files, Minimum Data Set (MDS) discharge assessment, and all orders, recommendations or guidelines from the resident's attending physician must be provided to the receiving facility or other provider at the time of the resident's discharge or relocation.

FEDERAL RULES



NOTICE

Administrator Notice

- The facility's notifications should be developed with input from the facility's Medical Director and other management staff and include a summary of key details from the closure plan for the safe and orderly transfer, discharge and adequate relocation of all residents.

FEDERAL RULES

- In addition to written notification, facility staff should discuss (orally) this information with residents, their families and/or legal representatives in order to provide a better understanding of the situation and their rights. Notice of facility closure to residents and their legal or other responsible parties must be provided in a language and manner they understand.



NOTICE

FEDERAL RULES

The notice must include:

- the name, address and telephone number of the State LTC ombudsman
- for residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act
- for residents with mental illness, the mailing address and telephone number of the agency responsible for the protection and advocacy of individuals with mental illness established under the Protection and Advocacy for Mentally Ill Individuals Act
- contact information for the primary facility contact(s) responsible for the daily operation and management of the facility during the facility's closure process

FEDERAL RULES



Closure Plans

- LTC facilities must include in their closure notices a **plan**, approved by the State, for the transfer and adequate relocation of residents of the facility by a specified date prior to closure.
- The notices 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.**

FEDERAL RULES: PLANS

CMS **expects** that the closure plan would include sufficient detail to clearly identify the steps the facility would take, and the individual responsible for ensuring the steps are successfully carried out, such as:

- Assurance that no new residents will be admitted to the facility on or after the date that the written notice of impending closure was provided to the State Survey Agency.

FEDERAL RULES: PLANS

- The primary contact(s) responsible for the daily operation and management of the facility during the facility's closure process.
- The primary contact(s) responsible for the oversight of those managing the facility operations during the closure process.
- The roles and responsibilities of the facility's owners, administrator, or their replacement(s) or temporary managers/monitors during the closure process.

FEDERAL RULES: PLANS

- Identification of any and all sources of supplemental funding, if available, to assist in maintaining the facility's daily operations until all residents are safely relocated and/or transferred.
- The process and procedures for providing timely written notification of the facility's impending closure, including its closure plan to the State Survey Agency, the State's LTC ombudsman, residents, their legal representatives or other responsible parties and the resident's primary physician.

FEDERAL RULES: PLANS

- The process for providing notification of the facility's impending closure, including its closure plan to all facility staff, vendors, contractors and unions as appropriate.

FEDERAL RULES: PLANS

- The provisions for ongoing operations and management of the facility and its residents and staff during the closure process that include:
 - payment of salaries and expenses to staff, vendors, contractors, etc.
 - continuation of appropriate staffing to meet the needs of all residents.
 - ongoing assessment of each residents' care needs and the ongoing provision of necessary services and care including the provision of medications, services, supplies and treatments as ordered by the resident's physician/practitioner.

FEDERAL RULES: PLANS

- ongoing accounting, maintenance and reporting of resident personal funds
- the provision of appropriate resident care information to the receiving facility to ensure continuity of care
- the labeling, safekeeping and appropriate transfer of residents' personal belongings, such as clothing, medications, furnishings, etc. at the time of transfer or relocation including contact information for missing items after the facility has closed

FEDERAL RULES: PLANS

A process that provides assurance for how the closing facility will identify available facilities or other settings in terms of quality, services, and location, taking into consideration the need, choice, and best interests of each resident.

FEDERAL RULES: PLANS

- Provisions for sufficient preparation and orientation to residents to ensure a safe and orderly move from the facility might include:
 - interviewing residents and their legal or other responsible parties, where applicable, to determine each resident's goals, preferences, and needs in planning for the services, location, and setting to which they will be moved

FEDERAL RULES: PLANS

- offering each resident the opportunity to obtain information regarding their community options, including setting and location; providing residents with information or access to information pertaining to the quality of the providers and/or services they are considering; psychological preparation or counseling of each resident as necessary
- making every reasonable effort to accommodate each resident's goals, preferences and needs regarding receipt of services, location and setting

FEDERAL RULES:ADMINISTRATOR SANCTIONS



- A civil monetary penalty of up to \$100,000.
 - A minimum of \$500 for the first offense.
 - A minimum of \$1,500 for the second offense
 - A minimum of \$3,000 for the third and subsequent offenses.
 - An administrator could be subject to higher amounts of CMPs (not to exceed \$100,000)
- May be subject to exclusion from participation in any Federal health care program.
- Shall be subject to any other penalties that may be prescribed by law.
- Any sanctions that have been levied against an administrator would also be reviewed by the State's licensing agency for possible disciplinary action including suspension and termination of the administrator's license.

FEDERAL RULES: PAYMENTS

When a notification is made the Secretary will continue to make payments to the SNF or, for a NF, to the State, as the Secretary considers appropriate, during the period beginning at the time the notification is submitted and until the resident is successfully relocated.

Training: Nursing Home Closures

SUPPORTED WITH A GRANT FROM RETIREMENT RESEARCH FOUNDATION

THE NATIONAL CONSUMER VOICE FOR QUALITY LONG TERM CARE

CYNTHIA RUDDER, PHD

DAY ONE: AFTERNOON

- Discussion of strengths and weaknesses
- Choosing one recommendation to work on
- Developing a strategic plan
- Developing the work plan for the next 12 months

FIRST DAY: 1:00 TO 1:30

DISCUSSION OF STRENGTHS AND WEAKNESSES



What do you see as your strengths and weaknesses in relation to your ability to be successful in achieving the goal (in addition to the goal of developing a functioning transition team) that you will choose to focus on during the next 12 months?

DISCUSSION OF STRENGTHS AND WEAKNESSES

What kind of relationship do you have with:

- State surveyors
- Legislature
- Providers
- Other advocates
 - AARP
 - Alzheimer's Assoc.
 - Disability Groups
 - Independent Living Centers
- Governor
- Other state agencies



FIRST DAY: 1:30 TO 2:00

CHOOSING YOUR GOAL

- Which of the recommendations are relevant to your state?
- Which are important to you?
- Which are practicable and achievable?



CHOOSE ONE RECOMMENDATION

- Pass a rule requiring that a 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
- Pass a rule that the State Ombudsman must be able to review and comment on the facility's closure plan prior to the state approving the plan

CHOOSE ONE RECOMMENDATION

- Develop a system for residents and families to file complaints with the state about how the closure is being carried out which will receive an immediate response from the state regulatory agency. These complaints will also be reviewed by the state to identify problems; perform root cause analysis; make improvement based on analysis
- Pass a state law to require a public hearing before a facility can voluntarily close
- Pass a law or a regulation that will mandate that a facility 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 receivership

CHOOSE ONE RECOMMENDATION

- Pass a regulation to require the closing facility to report staffing on each shift each day to make sure they have adequate staff to care for the residents and require the closing facility to hire contract staff if needed; and
- Pass a regulation to require the receiving facility to develop a plan to minimize transfer trauma for residents being admitted from the closing facility.

BREAK 2:00 TO 2:15



DEVELOPING A STRATEGIC PLAN: 2:15 TO 3:45



DEVELOPING A STRATEGIC PLAN

- Who are the other stakeholders?
- What influence do these stakeholders have?
- What are the arguments that might be used by those opposing your objectives?

What is the political context in your state?

- Are you able to go to the media?
- Are you able to confront state officials?
- Who makes the decisions on these issues?
- Who helps or influences these decisions?

DEVELOPING A STRATEGIC PLAN

- What materials can you use?
- What allies can you engage?

- What activities will you undertake to achieve the objectives you chose?

DEVELOPING A STRATEGIC PLAN

- Does implementation of your objective mean a new law?
A new regulation? A new guideline?
- What are your short term goals?
 - Raising awareness
 - Developing relationships with allies
- Is there anything happening in your state that might be used as a starting off point?
 - A difficult closure?
 - A news article that gathered interest?

MEDIA



- Is the issue being covered by print or broadcast media?
- Are there other issues already receiving attention that can be linked to your objective?
- Who is reporting on nursing home issues or issues relating to closures? Do you have, or can you form, a relationship with her or him?
- Are there any stories you have or know of that could help encourage media attention?
- What other stories could help improve your case?
- Can you link the story to another local, topical or historical event?

EVALUATION OF SUCCESS



How will you evaluate your progress?

- Did you achieve your objectives?
- Which activities were the most successful? Which were not successful? Why or why not?
- Have you been able to get people in decision-making power to discuss the issue?
- Were you able to identify all of the stakeholders?
- Are you able to understand their perspectives?

First Day:

3:45 to 4:30

DEVELOPING THE WORK PLAN
FOR THE NEXT 12 MONTHS

DEVELOPMENT OF WORK PLAN



Training: Nursing Home Closures

SUPPORTED WITH A GRANT FROM RETIREMENT RESEARCH FOUNDATION
THE NATIONAL CONSUMER VOICE FOR QUALITY LONG TERM CARE
CYNTHIA RUDDER, PHD

DAY TWO



Transition Team

- Developing a Transition Team
 - Best practices
 - Things to consider
 - What activities do you think you will need to undertake?
 - Development of a 12 month work plan
- Evaluation of the Training

SECOND DAY: 9:00 TO 10:00

TRANSITION TEAMS: BEST PRACTICES

OHIO

- Kaizen Event

A *kaizen* event is a discrete continuous improvement project with a defined start and end point, usually done in a single week.

A typical *kaizen* event consists of a day of training, a day of process walking and analyzing the process, followed by two days of improvement activity. The final morning (Friday) is used for wrap-up, training on the new process, and preparing a report out, which is usually presented late morning or early afternoon.



TRANSITION TEAMS: BEST PRACTICES

- **Issue in OHIO:** 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.

“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.



Members of the core group attending this event included:

- State Long-Term Care Ombudsman
- Ombudsman Project Coordinator
- Department of Medicaid
- Department of Health
- Department of Mental Health and Addiction Service

Later in the process, other agencies were added:

- Ohio Department of Aging's Division of Community Living which hosts the senior Home and Community Based Services and Assisted Living Medicaid waivers
- Ohio Department of Medicaid as the primary liaison to the managed care organizations
- Ohio Department of Developmental Disabilities

The team worked nonstop for five intense days, creating a process that reduced the administrative burden and led to better outcomes for residents.



The team's newly created process spells out who does what, ensuring that each job is in the right hands.



EXAMPLES OF CHANGES: OHIO

Assessments of each resident will be done very early in the process, to allow more time and better coordination. These assessments gather important information to match the individual with available programs, services, residences, and facilities.

The new process also builds in a face-to-face family meeting. This gives everyone a chance to talk through the various relocation-related options.

Another team-led improvement relates to information-sharing. Previously, all the different parties in this complex equation had to use email, print-outs, or phone calls to circulate information. The new process will use SharePoint as a shared database, guaranteeing that people from different agencies have real-time access to all a full set of information.

EXAMPLES OF CHANGES: OHIO

Updating the relocation manual used by agency to include:

- a summary of activities to be conducted in advance of residence terminations.
- information about SharePoint access and contents,
- clear language on roles and responsibilities and relocation activities.
- a high-level process map.
- newly standardized forms and templates (including templates of letters to families), frequently used contact information, and more.



MORE EFFICIENT: OHIO

These major improvements translated into impressive numbers. According to team estimates, the State Ombudsman office was spending the equivalent of 12 full days of work getting ready for a relocation. When the new process is fully in place, it will take an estimated total of 5 days, cutting the time in half and then some.

RELOCATION TEAM: EXAMPLE OF THE DIFFERENT ROLES: OHIO

Ohio Medicaid/County Departments of Job and Family Services –

- Maintains compliance with federal regulations regarding payment and certification.
- Staff reviews resident eligibility and potential for community living, 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.

RELOCATION TEAM: OHIO

Ohio Department of Aging/Area Agency on Aging –

- 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.

RELOCATION TEAM: OHIO

Office of the State Long-Term Care Ombudsman—

- 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.
- 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.

PROCESS: OHIO

The Team meets regularly even if a closure is not imminent to discuss issues.

The actual closure work of the team begins when the Ohio Department of Health's Bureau of Long Term Care (regulatory bureau) sends an alert to the State Ombudsman within sixty days of a possible termination date. The Ombudsman Project Coordinator alerts the full Team. This alert starts a "data mining period."

The Department of Medicaid pulls together data on all the Medicaid residents in the home using the MDS (Minimum Data Set).

PROCESS: OHIO

The local ombudsman adds data for non-Medicaid residents using the facility's census list and resident interviews.

The whole group 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.

PROCESS: OHIO

All collected data is stored in a master spreadsheet by the Office of the State Long-Term Care Ombudsman and shared confidentially.

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.

“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.

WISCONSIN

Ombudsman Office - Relocation Specialist

- Initially used CMP funds
- Now permanent

WISCONSIN: RELOCATION TEAM

- Division of Long Term Care
- Facility
- Resident Relocation Specialist Ombudsman for individuals over the age of sixty (60)
- Disability Rights Wisconsin (DRW) for individuals under the age of sixty (60) who have developmental, mental and/or physical disabilities.

WISCONSIN: RELOCATION TEAM

- Staff from the Aging and Disability Resource Center in the county where the closing facility is located.
- Staff from the responsible county Adult Protective Services Unit(s) may be consulted where there are concerns regarding guardianship and/or protective placement.

WISCONSIN: RELOCATION TEAM

Other Department Staff who may be asked to review the Resident Relocation Plan, conduct on-site visits or participate as a member of the State Relocation Team on an as needed basis would include the following:

- Program Bureaus within the Division of Long Term Care.
- The Division of Quality Assurance and its various regulatory Bureaus.
- The Division of Mental Health and Substance Abuse Services and its various program Bureaus.
- Area Administration, Division of Enterprise Services. The Office of Legal Counsel.

WISCONSIN: RELOCATION TEAM

Liaisons to the Resident Relocation Team

- Staff from the Managed Care Organization representing currently enrolled members who are residents of the facility or newly enrolled members.
- Staff from IRIS Independent Consultant Agency (Helping people get home care).
- Staff from health maintenance organizations/insurance plans who have currently enrolled members who are residents of the facilities.

“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

THE RESPONSIBILITY OF ALL MEMBERS OF THE STATE RELOCATION TEAM

- Participate in the initial announcement of closure meeting for residents and their representatives.
- Participate in the resident and family informational meeting conveying the options available for assistance in the relocation effort and their role in ensuring the resident is able to access them and achieve an appropriate alternate setting.



THE RESPONSIBILITY OF ALL MEMBERS OF THE STATE RELOCATION TEAM

- Facilitate the development of the individualized relocation plan and its timely progression.
Ensure options counseling is available for all residents.
- Ensure that resident needs, preferences, and choices are met.

THE RESPONSIBILITY OF ALL MEMBERS OF THE STATE RELOCATION TEAM

Ensure that the following elements are present in the development of the individualized relocation plan:

- Residents are assured of their right to participate in their discharge plan.
- Ensure relocation information is provided to residents and/or their designated decision maker to provide for informed choice.
- Ensure counties, ADRCs, MCOs and IRIS consultants are involved in fulfilling their responsibilities in helping the residents relocate.
- The resident relocation plan is implemented and timely progression is maintained.
- The resident relocation plan is being followed.
- Areas of concern in the plan are addressed.

THE RESPONSIBILITY OF ALL MEMBERS OF THE STATE RELOCATION TEAM

Identify and facilitate the removal of barriers to transition and potential residential options.

Follow up, post relocation, on any resident whose relocation may have been potentially problematic or may have resulted in an unexpected outcome.

Be a resource for the resident and facility throughout the relocation process.

Maintain confidentiality and adhere to the HIPAA (Health Care Insurance Portability and Accountability Act) guidelines relating to health care information.

WISCONSIN: SPECIFIC ROLES

Division of Long Term Care (State Relocation Team Lead): Leads the team, orients team members, coordinates all activities and monitors the closing and conducts the “Lessons Learned Meeting” when the closure is completed.

Division of Long Term Care (Family Care Expansion and Member Care Specialist): Works with their assigned Managed Care Organizations (MCO) to plan for and add capacity to serve relocating residents who are their members.

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

WISCONSIN: SPECIFIC ROLES

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 ombudsman, and liaising with the Division of Long Term Care's Relocation Specialist almost daily.

Disability Rights Wisconsin for residents under 60 years of age: Considers whether the resident can live in the community and 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. The Survey Director is not a regular member of the Team.

WISCONSIN:ROLES

Aging and Disability Resource Center: To offer residents, relocating from a facility that is downsizing or closing, the same services that it would make available to its other ADRC customers (help in accessing long term care programs and services). Provision of those services may be expedited because of the timelines required for closure, but the nature of the services provided is essentially the same.

WISCONSIN RELOCATION MANUAL*

The manual is 146 pages and includes:

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

WISCONSIN: PROCESS

- Initial Orientation Meeting For State Relocation Team Members
 - Key participants are the members of the State Relocation Team. The relocation team lead will discuss the purpose and establish a time for the meeting with facility representatives including the facility relocation coordinator. The advocacy team members will be represented depending on the characteristics of the residents, i.e. over 60 years, less than 60 years, disabilities.
- Meeting with facility staff
- Meeting with residents
- Meet at least weekly at the facility or via teleconference to review each resident's relocation plan



Pennsylvania:

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).

BREAK: 10:00 to 10:15

SECOND DAY: 10:15 TO 10:45

Thinking about the practices of states like Ohio and Wisconsin?
What kinds of things will you need to consider?





WHAT ACTIVITIES DO YOU THINK YOU WILL
NEED TO UNDERTAKE?

SECOND DAY: 10:45 TO 11:30

DEVELOPMENT OF WORK PLAN



SECOND DAY: 11:30 TO 12

EVALUATION OF TRAINING



SECTION 2

EXECUTIVE SUMMARY FROM *SUCCESSFUL TRANSITIONS: REDUCING THE NEGATIVE IMPACT OF NURSING HOME CLOSURES*

SUCCESSFUL TRANSITIONS: REDUCING THE NEGATIVE IMPACT OF NURSING HOME CLOSURES¹

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).² 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.³ 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

¹ For entire study, see http://theconsumervoice.org/uploads/files/issues/CV_Closure_Report_-_FINAL_FINAL_FULL_APPENDIX.PDF.

² Manion, P.S. & Rantz, M.J., *Relocation Stress Syndrome: A Comprehensive Plan for Long-Term Care Admissions*, 16 Geriatric Nursing, May/June 1995.

³ 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.*

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 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"> • Give the receiving facility monetary incentives to take a resident. • More fines, regulations and oversight. • Encourage the receiving facility to take residents who are difficult to place.
Lack of communication, including accurate information, with residents and families.	<ul style="list-style-type: none"> • Obtain participation of the Ombudsman early. • Require new protocols and rules.
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"> • Require an outside entity to conduct the discharge planning. • Ensure that ombudsmen participate in informing residents/families about rights, options. • Require that the State Ombudsman see and comment on closure plan before state approval. • Give the ombudsmen a list of all residents being moved, including what new location and when movement occurred. • Promulgate new rules related to how discharges are handled on day of transition.
Staffing issues such as staff leaving, staff stress and bitterness.	<ul style="list-style-type: none"> • Provide/require more training and education on closure issues. • Be sensitive to staff who may be frightened or bitter due to the closure. • Provide assistance and referrals for new job opportunities once the facility has closed. • Promulgate new rules related to staffing numbers, closure plans, staff payment accounts, state supplement of staff if needed, bonuses and severance pay. • Ensure effective enforcement, including fines, if resident care and quality of life is compromised due to inadequate staffing levels.
Transfer trauma experienced by residents.	<p>BEFORE MOVE</p> <ul style="list-style-type: none"> • Give residents control over where they move. • Prepare residents for relocation. <p>AFTER MOVE</p> <ul style="list-style-type: none"> • Assist residents in adjusting to new location.
Poor notice/ not enough time.	<ul style="list-style-type: none"> • Require more notice to residents and families of an impending closure. • Put notice rules into statute.

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.⁴

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

⁴ Public Act No. 16-8: An Act Concerning the Long-Term Care Ombudsman's Notice to Nursing Home Residents.

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.⁵ 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 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

⁵ <https://www.federalregister.gov/articles/2013/03/19/2013-06276/medicare-and-medicaid-programs-requirements-for-long-term-care-ltc-facilities-notice-of-facility>.

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 Transition⁶:

- 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.
- 4.** Require states to develop a closure manual for providers, which include checklists of tasks they must carry out before any resident is transferred.

⁶ Many of these recommendations addressing obstacles were suggested by respondents to the questionnaire who were experienced with nursing home closures.

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 STATES⁷

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.

Recommendations Addressing Obstacles to a Successful Transition⁸:

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.

⁷ “State” encompasses the State Legislature, Licensing/Regulatory agency, Medicaid Agency, State Administration

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

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.
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 Transition⁹:

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.
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

⁹ Many of these recommendations addressing obstacles were suggested by respondents to the questionnaire who were experienced with nursing home closures.

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 housing¹⁰. Continued examples raise additional questions that should be addressed by future research.

¹⁰ <http://www.wnyc.org/story/nursing-home-de-blasio-flouted-state-rules/>.

SECTION 3

STATE CASE STUDIES
FROM *SUCCESSFUL TRANSITIONS:*
REDUCING THE NEGATIVE IMPACT
OF NURSING HOME CLOSURES

STATE CASE STUDIES¹

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 states² 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,³ 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

¹ For entire study, see http://theconsumervoice.org/uploads/files/issues/CV_Closure_Report_-_FINAL_FINAL_FULL_APPENDIX.PDF.

² You will find information on some of these states in the Appendix.

³ 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.

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 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.⁴ 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

⁴ Public Act No. 16-8: An Act Concerning the Long-Term Care Ombudsman's Notice to Nursing Home Residents.

The event focused on the fact that:

“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.”⁵

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.⁶

⁵ Lean Ohio Kaizen Event Fact Sheet, Ohio Department of Aging, November 1, 2013.

⁶ 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).⁷ This shifted the focus from the payer role to the advocacy role.⁸ 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.

⁷ This did not include any additional funding.

⁸ Interview with Julie Evers, Medicaid Health Systems Administrator 3, Office of Medicaid, Ohio, January 25, 2016.

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 the possibility of closure and how the facility is doing.⁹ 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.¹⁰

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.¹¹ 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.

⁹ Interview with Jill Shonk, Bureau of Long Term Care, January 7, 2016.

¹⁰ 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."¹⁰

¹¹ See a copy of the resident form in Appendix

“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

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.¹²

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

¹² See copies in the Appendix

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.¹³

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.¹⁴

"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 Work¹⁵

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

¹³ Email with Erin Pettegrew, May 2, 2016.

¹⁴ Interview with Julie Evers, Medicaid Health System Administrator 3, Office of Medicaid.

¹⁵ Interview with Erin Pettegrew. September 29, 2015.

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.¹⁶

“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.¹⁷ 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.¹⁸

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.¹⁹ 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.

¹⁶ Interview with George Pelletier, Community Options Coordinator, PASRR Bureau, Department of Mental Health and Addiction Services, February 18, 2016.

¹⁷ Interview with Jane Black, Project Director for the MFP, January 4, 2016.

¹⁸ Interview with George Pelletier.

¹⁹ 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.²⁰

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.²¹
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.²²

²⁰ Interview with Julie Evers and email with Erin Pettegrew.

²¹ Interview with Erin Pettegrew.

²² Ibid.

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WISCONSIN

Voluntary Closures²³

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.²⁴ 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

²³ Wisconsin rarely has involuntary closures.

²⁴ 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.²⁵

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.²⁶ 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.²⁷ 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

²⁵ Email from Tom La Duke, Relocation specialist, May 3, 2016.

²⁶ Interview with Tom LaDuke, Relocation Specialist, December 1, 2015.

²⁷ 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.”²⁸

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 .²⁹

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.³⁰ 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.³¹

“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.³²

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

²⁸ Ibid.

²⁹ Ibid.

³⁰ Ibid.

³¹ See sample Introductory Letter (Appendix) to residents and family members.

³² 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,³³ 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.³⁴ 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.³⁵

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.³⁶

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

³³ *Making the Right Choice, You Have Rights, A Voice for Residents Should Your Facility Close and Relocation Stress Awareness*: State Ombudsman Office.

³⁴ 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.

³⁵ Email from Tom LaDuke, May 3, 2016.

³⁶ 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.”³⁷

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,³⁸ 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.

³⁷ Interview with Thomas LaDuke, December 1, 2015.

³⁸ 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*³⁹

The establishment of a Relocation Team is also in Wisconsin statute.⁴⁰ 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.⁴¹

³⁹ Relocation Manual.

⁴⁰ Chapter 50, Wis. Stats.

⁴¹ 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 worksheet⁴² 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 Roles⁴³

The Relocation Manual clearly details the role of each Team member.⁴⁴

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

⁴² See Appendix for a copy of this outline.

⁴³ 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.

⁴⁴ Ibid.

ombudsman, and liaising with the Division of Long Term Care's Relocation Specialist almost daily.⁴⁵

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.⁴⁶ 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 law⁴⁷ 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.⁴⁸

Unique Inclusions in the Required Relocation Plan:⁴⁹ 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.⁵⁰ 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

⁴⁵ Tom La Duke, February 15, 2016.

⁴⁶ Interview with Otis Woods, Wisconsin Survey Director, Department of Health Services, February 1, 2016.

⁴⁷ 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

⁴⁸ 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>.

⁴⁹ Ibid.

⁵⁰ 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.”⁵¹ 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.⁵²

“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

⁵¹ Relocation Manual.

⁵² 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.⁵³

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.

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⁵³ 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 Process⁵⁴

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.⁵⁵

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.⁵⁶ The notice letter must state that the Department has 90 days to make a decision to

⁵⁴ 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.

⁵⁵ Department of Social Services: Decision in the matter of: Docket Number 10-710, Courtland Gardens Health Center, Inc. July 1, 2010.

⁵⁶ 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.⁵⁷ 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).⁵⁸

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

⁵⁷ See, "Nursing Home Closing – Resident Rights and Options," Connecticut Legal Services, Inc., in Appendix.

⁵⁸ 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 statutes⁵⁹. 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.⁶⁰ 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."⁶¹ 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.⁶²

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.⁶³ 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

⁵⁹ Connecticut General Statute 17b-352

⁶⁰ Interview with Jennifer Glick, Director, Department of Mental Health and Addiction Services, February 1, 2016.

⁶¹ Ibid.

⁶² Interview with Kevin Brophy, Director of Elder Law, CT Legal Services, February 2, 2016.

⁶³ 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.⁶⁴

In the last five years, there have been 13 closures: 3 bankruptcies, 5 receiverships and 5 CON requests.⁶⁵

“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 Hearing⁶⁶

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

⁶⁴ Rich Wysocki, Principal Cost Analyst, Department of Social Services, February 25, 2016.

⁶⁵ Ibid, February 2, 2016.

⁶⁶ 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.⁶⁷

“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.⁶⁸

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.⁶⁹

“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:⁷⁰

“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.”

⁶⁷ Chapter 368v* Health Care Institutions, Sec. 19a-486.e.

⁶⁸ Interview with Deborah Chernoff, Public Policy Director, New England Employees Union, District 1199, SEIU, February 2, 2016.

⁶⁹ **Conn. General Statutes, Chapter 368v*, Health Care Institutions, 19 a - 545.**

⁷⁰Wethersfield 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.⁷¹ 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 Facilities⁷²

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.⁷³

⁷¹ Senate Bill No. 1127, Public Act No. 11-233.

⁷² See Appendix for a copy of this initiative.

⁷³ 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."⁷⁴

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.⁷⁵ 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.

⁷⁴ Agency Legislative Proposal – 2016 Session: 11302015_SDA_LTCOP/CON.

⁷⁵ Public Act 14-55, section 2 [1] and section 17-339 of the Connecticut General Statutes.

- Union representatives⁷⁶ 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 kbrophy@connlegalservices.org</p>	<p>Deborah Chernoff Public Policy Director, Connecticut New England Health Employees Union, District 1199, SEIU 860-251-6042 dchernoff@seiu1199ne.org</p>
<p>Jennifer Glick Director Department of Mental Health and Addiction Services 860-262-5818 Jennifer.glick@ct.gov</p>	<p>Dawn Lambert, Project Director, Medicaid Rebalancing Initiative, Medicaid Agency 860-424-4897 Dawn.lambert@ct.gov</p>
<p>Mairead Painter, Manager, Medicaid Rebalancing Initiative, Medicaid Agency Department of Social Services 860-424-4897 Mairead.painter@ct.gov</p>	<p>Nancy Shaffer Connecticut State Long Term Care Ombudsman 860-424-5238 Nancy.shaffer@ct.gov</p>
<p>Rich Wysocki Principal Cost Analyst Department of Social Services 860-424-5103 Rich.wysocki@ct.gov</p>	

⁷⁶ 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 below⁷⁷. 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

⁷⁷ Most of these states were identified by the respondents to the on-line survey.

515-393-1710

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.⁷⁸

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.

⁷⁸ 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

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”⁷⁹ 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

⁷⁹ 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

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

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

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 action⁸⁰ 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

⁸⁰ 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.⁸¹

Contact:

Mary Ann B. Parker

Attorney

DC Long-Term Care Ombudsman Program

Legal Counsel for the Elderly

601 E Street, NW

Washington, DC 20049

(202) 434-2116

(202) 434-6595 (fax)

⁸¹ <https://beta.code.dccouncil.us/dc/council/code/sections/44-1002.03.html>.

SECTION 4

FEDERAL & SAMPLE STATE GUIDELINES ON CLOSURES

Issue Brief: Nursing Home Closures

Executive Summary

Facilities are required to provide written notification of an impending closure to the State Survey Agency, the State LTC Ombudsmen, residents of the facility, and their resident representatives at least 60 days prior to the date of the closure, or when the Secretary deems appropriate. The notice must include: (1) information on the facility's closure plan for the transfer and adequate relocation of residents, (2) assurances residents will be transferred to the most appropriate setting, (3) appeal rights information, and (4) contact information of the State Long-Term Care Ombudsman Program. The closing facility is responsible for documenting and communicating a variety of information to the receiving facility, including contact information for resident representatives, comprehensive care plan goals, and any other information to ensure a safe and orderly discharge. The closing facility is not allowed to admit any new residents during the closure. The closing facility must provide a transfer orientation for residents. If the Secretary deems appropriate, the closing facility may continue to receive payments for long-term care residents for the duration of the closure.

Notice Requirements

Federal regulations require the administrator of a nursing facility provide written notification of an impending closure to the State Survey Agency, the State LTC Ombudsman, residents of the facility, and their resident representatives or other responsible parties.¹ The written notification must be given at least 60 days prior to the date of the closure, or, in the case of a facility being terminated from participation in Medicare and/or Medicaid, not later than the date the Secretary (of Health & Human Services) determines to be appropriate².

The notice must also include the facility's State-approved closure plan for the transfer and adequate relocation of the residents; as well as assurances that the residents will be transferred to the most appropriate facility or setting, in terms of quality, services, and location, and considering the needs, choice, and best interests of each resident.³

The facility must have policies and procedures in place ensuring that the administrator's duties and responsibilities involve providing appropriate notices in the event of facility closure.⁴

¹ 42 C.F.R. 483.70(l)(1)

² 483.70(l)(1)(i) – 483.70(l)(1)(ii)

³ 483.70(l)(3)

⁴ 483.70(m)

The notice is required to have the following information:⁵

- The reason for transfer or discharge (i.e. closure)⁶
- The effective date of transfer or discharge⁷
- The location to which the resident will be transferred⁸
- Information on the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives appeal requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request⁹
- Name, address (mailing and email), and telephone number of the Office of the State Long-Term Care Ombudsman¹⁰
- For nursing residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities¹¹
- For nursing residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder¹²

If the information in the notice is changed before the effective date of the transfer, then the facility must update the recipients of the notice as soon as practicable.¹³

May Not Admit New Residents

Once the notice of closure is submitted to the State Survey Agency and other listed entities and individuals, the administrator must ensure that the facility does not admit any new residents¹⁴.

Required Documentation/Communication

The facility is required to ensure that for each resident being transferred or discharged, the basis for the transfer is documented by in his/her medical record:¹⁵

⁵ 483.15(c)(5)

⁶ 483.15(c)(5)(i)

⁷ 483.15(c)(5)(ii)

⁸ 483.15(c)(5)(iii)

⁹ 483.15(c)(5)(iv)

¹⁰ 483.15(c)(5)(v)

¹¹ 483.15(c)(5)(vi)

¹² 483.15(c)(5)(vii)

¹³ 483.15(c)(6)

¹⁴ 483.70(l)(2)

¹⁵ 483.15(c)(2) & 483.15(c)(2)(i)(A)

The closing facility must provide, at minimum, the following information to the receiving facility:¹⁶

- Contact information of the practitioner responsible for the care of the resident¹⁷
- Resident representative information including contact information¹⁸
- Advance Directive information if the resident has one¹⁹
- All special instructions or precautions for ongoing care²⁰
- Comprehensive care plan goals²¹
- All other necessary information, including a copy of the resident's discharge summary and any other documentation necessary to ensure a safe and effective transition of care²²

Orientation for Transfer or Discharge

A closing facility must provide an orientation to residents to ensure a safe and orderly transfer from the facility. This orientation must be provided in a form and manner that the resident can understand. The closing facility must document this orientation.²³

Continuation of Payments from CMS

As the Secretary deems appropriate, CMS may continue payments with respect to residents of a long-term care facility that is closing and has submitted a notification of closure. CMS may continue payments during the period beginning on the date of closure notification and ending on the date which the residents are successfully relocated.²⁴

¹⁶ 483.15(c)(2)(iii)

¹⁷ 483.15(c)(2)(iii)(A)

¹⁸ 483.15(c)(2)(iii)(B)

¹⁹ 483.15(c)(2)(iii)(C)

²⁰ 483.15(c)(2)(iii)(D)

²¹ 483.15(c)(2)(iii)(E)

²² 483.15(c)(2)(iii)(F)

²³ 483.15(c)(7)

²⁴ 42 C.F.R. 488.450(c)(2)

Federal Closure Rules

Medicare and Medicaid Programs;
Requirements for Long-Term Care (LTC)
Facilities; Notice of Facility Closure

Federal Register

Vol. 78

No. 53

Federal Nursing Home Regulations

Medicare and Medicaid Programs;
Requirements for Long-Term Care Facilities

Federal Register

Vol. 81

No. 192

Rhode Island – Closure Guidelines



RI Department of Health
Environmental and Health Services Regulation
Office of Facilities Regulation:

September 2012

Health Facility/Program/Residence Closure Guidelines

When a health care facility, program, assisted living residence, or supported care home Licensee enters into bankruptcy/foreclosure or determines that they will voluntarily cease operations, or upon notification/order from the Department to cease operations, the Licensee must meet with the Department and/or the state's Medicaid closure committee to discuss the Licensee's situation and the closure process. Upon request and as far in advance of the official "public" notice of closure as possible, the Licensee will submit a written Licensee Closure Plan for the Department's review.

In general, a non-residence (I.e., out-patient, less than 24 hour program) Licensee need only provide a written outline of their closure time line, patient/public notice plans, and medical record storage arrangements.

Minimally, a hospital, nursing facility, or assisted living residence closure plan must include the following:

- 1. Letter of intent and/or determining factors/justification for the closure (i.e., voluntary, financial), to include:**
 - a. Proposed closure date;
 - b. Contact information for staff member responsible for implementing the closure plan;
 - c. Projected fiscal management plan covering operations during the closure period.
- 2. Staffing plan(s):**
 - a. By unit/program/location;
 - b. Time line for individual closures of any unit/program/service location;
 - c. Staff scale-down process as appropriate given planned transition/reduction of patients/residents.
- 3. Plans for providing notification and estimated implementation of notices¹:**
 - a. Notice to 3rd party payers (i.e., Medicare/Medicaid);
 - b. Notice to Accreditation entities – where appropriate;
 - c. Notice to staff/union – meeting date(s);
 - d. Public notice;
 - e. Community/public meetings – if appropriate and/or planned.
- 4. Storage/access to medical records:**
 - a. Location for self-storage, or
 - b. Company/agency providing contract storage services

¹ Please provide draft copies of closure notices with your closure plan.

Rhode Island – Notice of Your Transfer and Discharge Rights

NOTICE OF YOUR TRANSFER AND DISCHARGE RIGHTS

BY LAW, AS A RESIDENT OF THIS NURSING FACILITY, YOU HAVE CERTAIN RIGHTS ABOUT ANY DECISION TO MOVE YOU FROM THIS NURSING FACILITY.

- YOU MAY NOT BE MOVED FROM THIS NURSING FACILITY UNLESS IT IS FOR ONE OF THE FOLLOWING REASONS:
 1. THIS NURSING FACILITY CAN NO LONGER PROVIDE THE KIND OF CARE YOU NEED;
 2. YOU NO LONGER NEED THE KIND OF CARE PROVIDED BY THIS NURSING FACILITY;
 3. YOUR SAFETY, OR THE SAFETY OF OTHERS, IN THIS NURSING FACILITY IS AT RISK;
 4. YOUR HEALTH OR THE HEALTH OF OTHERS, IN THE NURSING FACILITY IS AT RISK;
 5. YOU FAIL, AFTER BEING GIVEN NOTICE, TO PAY OR TO HAVE SOMEONE PAY FOR YOUR STAY AT THIS NURSING FACILITY;
 6. THIS NURSING FACILITY GOES OUT OF BUSINESS.
- YOU MUST BE TOLD AHEAD OF TIME ABOUT ANY DECISION TO MOVE YOU FROM THIS NURSING FACILITY.
- YOU MUST BE TOLD OF THE REASON FOR MOVING YOU.
- YOU HAVE THE RIGHT TO APPEAL THE DECISION TO MOVE YOU FROM THIS NURSING FACILITY.

IF YOU ARE TOLD YOU ARE BEING MOVED FROM THIS NURSING FACILITY AND YOU WANT TO HAVE A HEARING ABOUT THAT DECISION, CONTACT:

DEPARTMENT OF HUMAN SERVICES
HEARING OFFICE
600 NEW LONDON AVENUE
CRANSTON, RI 02920

TELEPHONE: 1-401-464-2326

Rhode Island – Actual Closure Plan from a Nursing Home

DISCONTINUANCE OF OPERATIONS

PLAN FOR

OCEAN STATE NURSING HOME, OCEAN VIEW, RHODE ISLAND

I. Introduction

This discontinuance of operations plan (this "Plan") was developed and is being submitted pursuant to the determination of the operator of Ocean State Nursing Home (the "Facility"), _____, and the proposed transferee of the right to operate the Facility, _____, to relocate the residents of the Facility and discontinue the operations of the Facility. Ocean State Nursing Home is a facility that is Medicaid certified and located at 1 Narragansett Blvd. Ocean View RI. The licensed bed capacity is Forty (40).

This Plan details the necessary steps and procedures in place and to be implemented to assure the orderly relocation of its residents. It is in accordance with the Department of Public Health ("DPH") and Division of Medical Assistance ("DMA") Regulations. This Plan assumes the receipt of all regulatory consents and approvals, including the approval of this Plan, on or about Sept. 1st, 2010. If all such consents and approvals are received at a different time, the dates set forth in this Plan would be adjusted accordingly. This Plan will become effective once all consents and approvals necessary for the above-described relocation of residents.

The Facility's responsibility for accomplishing the safe and orderly closure of the Facility and for assuring that residents receive appropriate care pending the closure, shall be coordinated by J. Michael Rose , Adm. on behalf of the Facility's management.

The underlying objective of this Plan is to insure a safe, orderly and clinically appropriate transfer of each and every resident and to assure the successful adjustment of each resident with a minimum of stress for residents, family and facility staff. This objective shall be accomplished in as expeditious a manner as possible under the circumstances. All time frames contained within this plan are reasonable approximations.

II. Notification

A. Resident/Family/Guardian

All residents and families will be given prompt written notice of the decision to discontinue the operations of Ocean State Nursing Home as well as personal notification by key facility management staff on or about Sept. 1, 2010. Written notice, in the form attached hereto as Exhibit A, will be given to each resident or representative at least thirty (30) days prior to transfer or discharge.

Beginning no later than Sept., 2010, continuous efforts will be made to notify resident spouses, family, next of kin and interested parties with additional effort applied for those residents who have not had steady family contact or who have no family or next of kin involved.

As part of the notification process, residents and families will be informed of the availability of key staff and the Facility's intention to provide them with essential information throughout the relocation process. Residents will be given additional notice at least five (5) days prior to actual transfer.

B. Public Agencies

The Department of Public Health has been notified of Ocean State Nursing Home discontinuance of operations and the Department of Medical Assistance will be notified once the Plan is accepted. Notification of other state agencies will begin at that time.

C. Attending Physicians

Attending physicians will receive verbal and written notification of the temporary discontinuance of the operations of the Facility on or about Sept. 1, 2010. Providers of clinical services, including pharmacy, mental health services, diagnostic services, etc. also will be notified on or about Sept 1, 2010.

D. Staff

All key staff members have or will be notified of the owner's decision to discontinue the operations of the Facility and the reason(s) therefor. General staff will be notified on Sept. 1, 2010. A log of notification contacts will maintained throughout the notification and relocation process.

III. Relocation Process

A. Preparatory Phase

Facility management staff will organize and conduct group sessions with residents and their families, next of kin, or interested parties, when available, to discuss the reasons for facility closure beginning Sept 1, 2010 at 10:00 a.m. Included in these discussions will be the details of the relocation plan, the provisions for support and assistance to locate new facilities, methods of dealing with adverse resident responses to relocation, and related issues such as continuity of medical and nursing care, financial considerations and scope of resident and family rights and responsibilities.

The goal of the discussions conducted initially and throughout the process will be full disclosure of critical information and assurance that residents who are sufficiently alert/oriented and family members will understand, as precisely as possible, what is to occur. All questions will be answered and issues resolved as completely and expeditiously as possible.

Representatives from key state and community agencies (Ombudsman, Council on Aging, etc.) will be invited to attend resident/family meetings to provide additional information and support to residents and their families. These agencies will be informed and updated regarding resident placement status throughout the relocation process.

The Administrator and Director of Nursing, with the assistance of a DMA Relocation Advisor, will be available to residents and their families during the notification period for advice, technical assistance and support. Psychological preparation or counseling by appropriate facility staff or mental health consultant(s) will be arranged as soon as possible.

B. Coordination with Public Agencies

The Administrator and Director of Nursing will coordinate nursing home bed location and placement efforts with DPH and DMA and will follow relocation guidelines.

C. Staff

Staff members will receive crucial information and counseling to assist them in identifying and appropriately responding to resident needs and problems associated with relocation. The content of such discussions and counseling will include:

- time frame for discontinuance of operations and relocation;
- possible resident and family reactions to relocation;
- methods of identifying resident and family adjustment problems;
- techniques for communicating information concerning relocation;
- steps of discharge planning process
- preparation of resident transfer; and
- transfer procedures, etc.

D. Relocation Procedure

Facility staff will complete all essential steps in the relocation procedure. Individual tasks and responsibilities will be assigned to specific staff members. Individual staff members will be held accountable for the following responsibilities:

- completion of resident assessments, including medical, physical, nursing and psychological information regarding current resident needs;
- location of appropriate available nursing home beds or other suitable placement;
- assignment of permanent staff member(s) responsible for discharge planning and transfer;
- recording all pertinent relocation information;
- establishment of a telephone log to record bed location and placement contacts;
- contact and utilize all available resources for bed location;
- coordination of resident referral screening by nursing homes;
- provision or arrangement of resident counseling adequate to prepare residents for successful transition;
- encourage and facilitate resident and/or family on-site visits to prospective facilities,

- where possible;
- identify resident's personal belongings and arrange for their transfer by the Facility with the resident or by the resident's family;
- forward entire medical record to facility to which resident is transferred and require that the accepting facility note its receipt of the record on a medical record
- receipt form which will be kept by Ocean State Nursing Home.; and
- complete appropriate resident referral form, which will be sent with each resident to his/her placement location.

E. Medical Records

The entire medical record (dating back to admission) of the resident will be sent to the receiving facility. The admitting facility will receive a letter explaining that the entire record was sent with the resident. The admitting facility will be required to sign an acknowledgment stating that such facility has received the medical record in its entirety.

Medical records of previously discharged residents will remain the responsibility of Ocean State Nursing Home and will be stored by:

Ocean State Nursing Home
1 Narragansett Blvd
Ocean View, RI 02888

F. Social Security

The Facility shall complete and mail, on behalf of each resident transferred, a social security change of address form. In addition, a SC-1 form shall be completed for each transferred resident and mailed to the Medicaid Long Term Care Unit.

G. Resident Funds

Funds in each resident's Personal Needs Account shall be transferred for the benefit of the resident. Medicaid auditors shall be informed of the relocation of residents and records of resident funds made available to them so they may track resident funds.

H. Visitation of Facilities

When applicable and requested, all residents, with the help of Social Services, will be given the opportunity to visit facilities of interest.

I. Medications

1. The Facility shall account for resident medications and transfer them with the resident.
2. Controlled substances will be sent with the documentation that pertains to each of the medications sent. A nurse from the transferring facility will count and sign off the drugs to the receiving nurse.

J. Maintenance Effort During Closing

Ocean State Nursing Home will operate at required staffing levels during the discontinuance of operations to ensure that adequate services are provided and the health and safety of the residents maintained.

The facility will conduct an orderly transfer and discharge process of no more than five (5) residents per day, unless a greater number is permitted by state agencies.

Admissions and readmissions to the facility will no longer be accepted.

K. Potential Facilities/Current Census

A. Potential Facilities

In cooperation with the DMA relocation team, Ocean State Nursing Home will identify facilities within a twenty-five (25) mile radius of the facility and/or family and friends that have potential for accepting Ocean State residents. A list of such facilities will be available to residents and families. Ocean State Nursing Home will not, however, limit its search to these facilities. Every effort will be made to keep placements within the greater Rhode Island area in accordance with resident and family preferences.

B. Census

Census of Ocean State Nursing Home as of August 8, 2010, is Thirty Seven (37), 34 of which services are paid for by the Medicaid Program.

FIRST REVISION 8-16-2010

Iowa – Closure/Crisis Team Intervention Process

Closure/Crisis Team Intervention Process¹

- I. Core Member learns of potential closure/crisis and notifies all Core members**
 - a. Core members discuss and verify closure/crisis
 - b. If no one is aware of situation proceed to next step

 - II. Potential closure/crisis is verified and/or situation is monitored**
 - a. Core member assigned task to verify information
 - b. Determinations made if there is an adequate plan of action-no further action needed
 - c. Determination made that there is an Inadequate plan of action or emergency

 - III. Report back to Core members**

 - IV. Call a Team Meeting**
 - a. DIA convenes meeting
 - b. Participants include: Core and appropriate additional team members
 - c. Ensure that all participants have the authority to hear and receive confidential information

 - V. Hold initial Team Meeting to discuss pending closure/crisis**
 - a. Agenda
 - i. Provide update
 - ii. Discuss reason of closure
 - iii. Goal date of closure
 - iv. Share agency roles and resources with facility
 - b. Core Team Members determine need for additional meetings
- Reference: Inform facility of S&C 13-50-NH letter (NFs & SNFs only)
Reference: Core and Additional Contacts
Reference: CFR, Administrative Rules and State Operations Manual (SOM)
- VI. On-site monitoring expands to Core Team**

 - VII. Determination is made from pending to imminent closure/crisis**
 - Compliance
 - Financial instability
 - Business decision
 - Fraud
 - Life Safety

¹ From “Iowa Long-Term Care Facility Closure/Crisis Team Procedures Manual” by Iowa Office of the State Long-Term Care Ombudsman (2016).

- a. Schedule another meeting with Core and Additional Team Members
- b. Instruct facility to send facesheets and identify potential harder to place individuals (vent, trach, behavior issues, court committals), and daily census reports
- c. Identify open beds in surrounding area of the state

VIII. Notification of Residents, Tenants, family/guardians and Staff by Facility when closure/crisis imminent

- a. Include vendors, physicians, therapists, other services
- b. CMS notifies DIA and publishes legal notice during involuntary closures (*42 CFR 488.456*)
- c. Facility work with Core team members to schedule resident/tenant and family meeting
- d. Letters to residents/tenants and families notifying them of closure include date and time of meeting

IX. Resident /Tenant and Family Meetings

Reference Meeting Agenda

X. Weekly Core and Additional Team Member Calls

- a. Discuss resident/tenant placements/census
- b. Relocation difficulties
- c. Operations
- d. Ensure all participants are covered by a release of information

XI. Agencies work with residents and tenants to find appropriate placement

- a. Social worker/Discharge planner takes the lead in finding placement
- b. Ensure residents/tenants have access to appropriate resources
- c. LLTCO complete follow-up visits with residents/tenants once relocated

XII. Facility begins discharge preparations – for individual residents and tenants

XIII. Facility Close

XIV. License or Certificate is surrendered

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.

SECTION 5

SAMPLE LETTERS TO RESIDENTS & FAMILIES



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



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

(REGIONAL NAME); Ombudsman
State Of Wisconsin-BOALTC
1402-Pankratz Street, Suite 111
Madison, WI 53704
(REGIONAL PHONE NUMBER)
1-800-815-0015
(REGIONAL) @wisconsin.gov

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 XXXXXXXXXXXX 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 XXXXXXXXXXXX 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



Telephone: (860) 424-5200

Toll Free: 1-866-388-1888

Website: 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





– Growing Older Together –

Telephone: (860) 424-5274

Toll Free: 1-866-218-6631

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Telephone: (860) 424-5200

Toll Free: 1-866-388-1888

Website: 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.
- **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





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.

246 N. High St. / 1st Fl.
Columbus, OH 43215-2406 U.S.A.
www.aging.ohio.gov

Main: (800) 282-1206 (TTY dial 711)
Fax: (614) 644-5201
Email: OhioOmbudsman@age.ohio.gov

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.

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

Iowa – Notification Letter to Residents

Notification to Residents/Tenants Template¹

(Date)

Dear (name of resident/tenant):

This letter is written pursuant to officially notify you that (NAME OF FACILITY) has made the very difficult decision to cease operations and will close the facility no later than (DATE OF CLOSURE-MUST BE AT LEAST 30 DAYS FROM THE DATE OF THIS LETTER).

We want you to know that we will be contacting each of you within the next few days regarding your relocation options. Please understand you have the right to seek placement at the facility of your choosing and we will assist you in finding a new home.

To assist you in that process, attached to this letter is a list of health facilities in (NAME OF COUNTY) County and surrounding counties with phone numbers and contact information. In addition, representatives from the Iowa Department of Inspections & Appeals, the Iowa Office of the State Long-Term Care Ombudsman, Iowa Department of Human Services and Disability Rights Iowa (see addresses and phone numbers below) will also be available to answer questions regarding the discharge procedure and alternative placement.

Iowa Department of Inspections & Appeals

Health Facilities Division
Lucas State Office Building
Des Moines, Iowa 50319-0083
515-281-4115

Office of the State Long-Term Care Ombudsman

Iowa Department on Aging
Jessie M. Parker Building
510 E. 12th Street, Suite 2
Des Moines, Iowa 50319-9025
1-866-236-1430 (toll free)

Iowa Department of Human Services

Medicaid Enterprise-Bureau of Long-Term Care
100 Army Post Road
Des Moines, Iowa 50315-6241
515-256-4600

Disability Rights Iowa

400 E. Court Avenue, Suite 300
Des Moines, Iowa 50309
1-800-779-2502 (toll free)

¹ From “Iowa Long-Term Care Facility Closure/Crisis Team Procedures Manual” by Office of the State Long-Term Care Ombudsman (2016).

SECTION 6

SAMPLE FORMS & CHECKLISTS

CHECKLIST TO USE FOR CLOSURES¹

Things to distribute:

- _____ Sheet with information contact (LTCOP, CMS, Consumer Advocacy Groups, etc.)
- _____ Residents' Rights Fact Sheet / Brochure
- _____ Know Your Rights During a Nursing Home Closure Brochure
- _____ Nursing home Place Options (Provide residents, family members and/or guardians with information about facilities and who to contact regarding other nursing homes in the area, recent survey information, etc.)
- _____ Placement Alternatives to Nursing Homes (Provide residents and family members with information and whom to contact regarding other types of placement such as board and care, personal care facilities, home health, etc.)
- _____ Letter informing each party (resident/family member/guardian/physician/legal representative/responsible party) of what is happening, if possible.

Actions to take:

- _____ Hold meeting(s) with residents/family members/legal representatives to inform of what is happening DATE(S):
- _____ Explain to each resident the reason for the relocation and the steps involved in the process

Need from nursing home on arrival:

- _____ List of all residents, family members, and legal representatives with telephone numbers
- _____ Date(s) of resident/family meetings
- _____ Date notification of closure sent to residents and family members
- _____ Copy of facility grievance procedure

¹ Adapted from LOCAL LONG-TERM CARE OMBUDSMAN "KIT" from, Murtiashaw, Sherer, The Role of Long-Term Care Ombudsmen In Nursing Home Closures And Natural Disasters: National Long Term Care Ombudsman Resource Center, January 2000.

Follow up needs:

- _____ Daily/weekly updates from facility
- _____ Roster of new homes where residents are transferred
- _____ Hold on-going meeting with residents and families to explain what is happening
- _____ Maintain on-going presence in the facility
- _____ Visit residents in new home or make arrangements for follow-up visits

Other:

- _____ Contact numbers of Lead Agency & others included in closure plan (cell phone numbers, e-mail addresses, night numbers will help in an emergency)
- _____ Contact numbers of State Ombudsman
- _____ Cash for meals and incidentals (closure may involve long hours in the facility)
- _____ Cell phone (facility phones are often tied up during these crisis situations)

**CHECKLIST FOR RESIDENT & FAMILY MEMBERS ON
TRANSFERRING PERSONAL ITEMS¹**

Items to be transferred with the resident are:

- _____ All medications
- _____ Complete medical record, including comprehensive care plan
- _____ Personal funds with full accounting
- _____ Family or legal representative contact information
- _____ Legal papers, such as powers of attorneys an advance directives
- _____ Personal property with inventory list – how will the property be transferred, who will pay the cost, phone service changes, if applicable, etc.
- _____ Identification with the resident

¹ Adapted from LOCAL LONG-TERM CARE OMBUDSMAN “KIT” from, Murtiashaw, Sherer, The Role of Long-Term Care Ombudsmen In Nursing Home Closures And Natural Disasters: National Long Term Care Ombudsman Resource Center, January 2000.

RESIDENT AND FAMILY INFORMATIONAL SHEET¹

IMPORTANT PEOPLE AND TELEPHONE NUMBERS:

Name(s) _____ Telephone # _____

Long-Term Care Ombudsman Program

Local Regulatory Staff

State Regulatory Staff

Legal Services

Regional CMS office

National CMS office

Temporary Manager

Adult Protective Services

Protection & Advocacy

After Hours Contact(s)

Members on Closure/Relocation Team:

¹ LOCAL LONG-TERM CARE OMBUDSMAN "KIT" from, Murtiashaw, Sherer, The Role of Long-Term Care Ombudsmen In Nursing Home Closures And Natural Disasters: National Long Term Care Ombudsman Resource Center, January 2000.

**RESIDENT CONTACT INFORMATION SHEET INCLUDING QUESTIONS FOR
RESIDENT INTERVIEW¹**

Name:

Room #

Payor:

Age:

Possible county of origin:

Guardian name (if applicable/known):

Guardian phone number (if applicable/known):

Family member name (if applicable/known):

Family phone number (if applicable/known):

DIAGNOSES:

- Alzheimer's?
- Dementia?
- Anxiety?
- Depression?
- Bipolar?
- Psychotic?
- Schizophrenia?
- PTSD?

Sex Offender Registry?

Proposed discharge:

Connected to Home Choice ?

PASRR Review:

Next action:

Comments:

Relocation representative:

¹ Adapted from "Initial Resident Contact to Merge 2015" form from Ohio Long-Term Care Ombudsman Program.

RESIDENT INTERVIEW:

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.*

Ask:

- 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? _____

IMPRESSIONS:

Impression of capacity:

Impression of less institutional possibilities:

Action items for follow up:

Home Choice Application DONE / NEEDED

Residential State Supplement App

 DONE / NEEDED

Long-Term Care Ombudsman Program Facility Closure CHECKLIST¹

Facility Name Closing:			Type of Facility: <input type="checkbox"/> NH <input type="checkbox"/> ALF <input type="checkbox"/> AFCH <input type="checkbox"/> SNU (Hospital)		
Ombudsman Assigned:			Date of Visit:		
Resident Name:			Room #:		
Address:			City:		County:
Date Facility Closing:					
Resident's Legal Representative or Family Member Name:			Relationship to Resident:		
Legal Authority: <input type="checkbox"/> POA <input type="checkbox"/> Healthcare Surrogate <input type="checkbox"/> Guardian <input type="checkbox"/> Other: _____			Address of Legal Representative:		
Phone Number of Representative:			Additional Information regarding Representative:		
Yes	No	N/A	ATTACH CONSENT FORM		
			<ul style="list-style-type: none"> • Is there an open case? If yes, what is the case # _____ Comment:		
			<ul style="list-style-type: none"> • Did you inform the resident of their rights? Comment:		
			<ul style="list-style-type: none"> • Was a brochure and Resident Rights Information provided to the resident? Comment:		
			<ul style="list-style-type: none"> • Was the resident given a choice of facilities to choose from? Comment:		
			<ul style="list-style-type: none"> • Did you provide a list of facilities to the resident? Comment:		
			<ul style="list-style-type: none"> • Was the Agency for Health Care Administration called? Comment:		
			<ul style="list-style-type: none"> • Was Adult Protective Services called? If yes, who is the Investigator? _____ Comment:		
			<ul style="list-style-type: none"> • Is there a Case Manager to assist the resident? If yes, who is the Case Manager? _____ Case Manager's Organization? _____ Comment:		
			<ul style="list-style-type: none"> • Are all personal belongings with the resident? Comment:		
			<ul style="list-style-type: none"> • Are all the medications with the resident? Comment:		
			<ul style="list-style-type: none"> • Is the resident due a refund of any kind from the facility? Comment:		
			<ul style="list-style-type: none"> • Is the resident and resident's representative satisfied with the current placement? Comment:		
			<ul style="list-style-type: none"> • Was the resident given a change of address form to inform the post office? If no, please provide a change of address form to resident. Comment:		

¹ Developed by the Florida State LTC Program in 2008. You can download the original form here:
<http://ltombudsman.org/uploads/files/issues/Facility-Closure-Checklist-2008.doc>.

			<ul style="list-style-type: none"> Does resident have a personal phone line service (land line)? If yes, please remind resident to make appropriate changes for phone service. Comment:
Other Issues:			
Facility Transferred To:		Date of Transfer:	
Address of New Facility:		Type of Facility: <input type="checkbox"/> NH <input type="checkbox"/> ALF <input type="checkbox"/> AFCH <input type="checkbox"/> SNU (Hospital) <input type="checkbox"/> Other _____	
Ombudsman Assigned to Visit with Resident at New Facility:		Date of Visit:	
Yes	No	N/A	ATTACH Resident Visitation Form
			<ul style="list-style-type: none"> Is the resident and resident's representative satisfied with the current placement? Comment:
			<ul style="list-style-type: none"> Is there a need to open a case? If so, please contact the District Ombudsman Manager to file a complaint. Comment:
Other Concerns:			
Ombudsman Signature:		Date:	

LTCO/Closure Team Needs & Information¹

Facility Name: _____ Date: _____

Prior to the transfer of residents the LTCO/Closure Team meets with the Administrator to discuss the process and the items necessary for a smooth transition.

Documentation requested from resident's records are to be copied by the facility and placed in folders Documentation requested may include but is not limited to:

- Resident's room number
- Indication of the city or town the resident resided in prior to coming to the facility
- Name of next of kin, responsible party or guardian and contact information
- Whether or not the resident is a smoker
- Any specialized services the resident is receiving (hospice, dialysis, etc.)
- Resident's payment source/individual contribution towards care/applied income
- Funeral arrangements on record
- Advanced Directives
- Copies of all insurance coverage
- PNA funds
- Primary language
- DOB
- Date of admission to facility

The Closure Team will add to each resident's folder the following forms: Emergency Resident Transfer Form and Progress Note Form

The facility is responsible for providing the following:

- Boxes and/or bags appropriate for all resident's belongings (plastic bags for toiletries and soiled laundry, and medications)
- Adhesive labels with resident's names and facility they are being transferred are to be made by facility and placed on each box/bag of resident belongings.
- A facility staff person will be assigned to oversee the packing of the resident's belongings and that non-boxed items are also labeled
- Water soluble bags will be used that dissolve in the wash cycle for any suspicion of insect infestation (bed bugs)

Additional Information:

The Closure Team will also meet with the social worker to discuss the needs of each resident as well as care or behavioral issues. This information is documented on a Progress Note Form in each resident's folder. The Progress note Form will also be used by the Closure Team for all notations regarding the transfer process.

¹ From "Facility Closure Information" by the Office of the Rhode Island Long Term Care Ombudsman Program located in Alliance for Better Long Term Care, Inc. (2017).

The facility will provide the Closure Team with an office containing desks/table/chairs, a telephone(s) access to a fax machine and a copy machine.

Facility will also provide appropriate meeting space for the Closure Team to meet with residents and their family/responsible party.

The Closure Team will maintain a log for team communication.

All resident discharges will be recorded on the Final Discharge List by the Closure Team.

LTCO Discharge 'To Do' List¹

24 hours prior to discharge:

- Arrange transportation (wheelchair or stretcher van). Find out who will be billed?
- Interagency (Long Form) completed and faxed over to receiving facility.
- If receiving facility requests, have staff place all resident clothing and washable belongings (including blankets and comforters). All other belongings can be boxed or bagged. Make sure everything is labeled as belongings may be transported separately. Check to make sure any religious items and wall hangings that belong to the resident are packed as well.
- Notify resident and next of kin of discharge.
- Find out about moving of large items such as televisions and heavy furniture.
- Have staff complete inventory sheets for resident's belongings.
- Plan narcotics transfer if needed.

Morning of discharge:

- Place the following documents in an envelope to be sent with the resident to the new facility:
 - o Medication sheets (copies)
 - o Interagency (original)
 - o Obtain Personal Needs money (in check form) as well as health card, funeral arrangements and any other important information from business office.
 - o Narcotic sheets (copy from med book).
 - o Make sure resident is prepared to leave with a change of clothing, jacket or sweater if needed and any small personal items such as a pocketbook or wallet.
- Alliance staff to write progress note and complete transfer form.

¹ From "Facility Closure Information" by the Office of the Rhode Island Long Term Care Ombudsman Program located in Alliance for Better Long Term Care, Inc. (2017).

Alliance For Better Long Term Care - Office of the Rhode Island Long Term Care Ombudsman

EMERGENCY RESIDENT TRANSFER FORM

Resident's Name: _____ Room#: _____

Resident notified of Transfer **Y N** Date: _____ Notified by: _____

Family Contact/Legal Representative: _____ Phone: _____

Notified of Transfer **Y N** Date: _____ Notified by: _____

Transfer Date: _____ Time: _____ Transferred From: _____

Transferred To: _____ Transported By: _____

PAPERWORK COMPLETED & RECORDS BEING SENT WITH RESIDENT

Face Sheet _____	Narcotics Sheet _____
Interagency-Long Form _____	
Current Medication & Treatment Sheet _____	
Recent Labs, Consults & X-Rays _____	
Last 30 Days of MD Orders _____	
Recent Skin Assessment _____	
Upcoming Dr. Appointments _____	
Immunization Record _____	
Last 30 Day of Nursing Notes _____	
Medical/Insurance Cards _____	

Social Work Notes (Last Qtr) _____	Social History _____
Recent Psych Notes & Consults _____	
Recent Activity Notes _____	Recent Care Plan _____
PASSR/ID Screen _____	Advanced Directives _____
Care plan _____	Legal Documents _____
Funeral Arrangement Information _____	Picture ID _____
PNA Funds _____	Amount \$ _____
• Other _____	_____

PERSONAL ITEMS BEING SENT WITH RESIDENT – ALL LABELED

Clothing & Shoes (<i>Including cleaned & soiled</i>) _____
Coats/Hats/Gloves/Scarves _____
Dentures _____ Hearing Aides _____
Eye Glasses _____ Contact Lenses _____
Wheelchair _____
Walker _____ Cane _____
Geri/Cardiac Chair _____
Prosthesis/Splint/Brace _____
Wig _____ Electric Shaver _____
Toiletries/Cosmetics _____
Jewelry _____
Wallet/Pocketbook _____
• Other Personal _____
Devices/Equipment _____

Telephone _____ Cell Phone _____
Answering Machine _____
Television _____ (<i>Including all wires & equipment, i.e. DVD Player</i>) _____

Computer _____
Laptop or Desktop? _____
(<i>Including all wires & equipment, i.e. printer</i>) _____

Radio/CD player _____
• Other _____
electronics _____

Furniture _____

Lamp _____
Wall Clock _____
Alarm Clock _____
Pillows _____
Blankets _____
Pictures/Art work _____
Religious/Spiritual Items _____
• Other Personal _____
Belongings _____

CANCELLATION/TRANSFER OF SERVICES

Cable _____ Newspaper _____	Notification of Address Change _____	Notification to SS Administration _____
-----------------------------	--------------------------------------	-----------------------------------------

Ombudsman/Staff responsible for check-out prior to transfer: _____

Follow-up call to new facility by: _____ Date: _____

DAILY SCHEDULED APPOINTMENTS¹

Ombudsman - Residents - Families

DATE: _____

TIME	RESIDENT NAME/FAMILY MEMBER(S)
10 AM	
11AM	
1PM	
2PM	
3PM	
4PM	
5PM	
6PM	
7PM	

¹ From "Facility Closure Information" by the Office of the Rhode Island Long Term Care Ombudsman Program located in Alliance for Better Long Term Care, Inc. (2017).

LTCO PROGRESS NOTES¹

RESIDENT: _____ DOB/AGE: _____ M/F: _____ SMOKER?: _____

PREFERRED
FACILITY/AREA:

SPECIAL ACCOMMODATIONS
NEEDED:

¹ From "Facility Closure Information" by the Office of the Rhode Island Long Term Care Ombudsman Program located in Alliance for Better Long Term Care, Inc. (2017).

SECTION 7

ADDITIONAL CONSUMER VOICE RESOURCES



Contacting Your Long-Term Care Ombudsman

Call (202) 332-2275

OR VISIT

[www.theconsumervoice.org/
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1. Click on your state
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The National Consumer Voice for Quality Long-Term Care (Consumer Voice) advocates for public policies that support quality of life in long-term care settings and educates the public on the issues that matter most to consumers.

Consumer Voice represents consumers and advocates who define and achieve quality for people with long-term care needs. If you are a resident and would like to make a difference, contact us today to learn more about how you can bring about change!



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Know Residents' Rights During a Nursing Home Closure

Guaranteeing a Successful Transition



What are your rights?

You have a right to:

- Receive written notice of the closure at least 60 days in advance that also includes the facility's closure plan and where they will be transferring you
- Your needs, preferences, and choices honored
- An orientation by the facility to prepare you for a safe and orderly transfer
- Information shared with the receiving provider, such as care plan goals, discharge summary, special instructions, etc.

What information should the notice include?

The notice should include:

- Facility's closure plan, date of transfer, location of transfer
- Assurances that you will be transferred to the most appropriate facility or setting with comparable quality, services and location
- Information on resident's appeal rights, including information on how to obtain the appeal form and help in submitting the appeal form
- Contact information for the Long-Term Care Ombudsman Program, who you can call if you have concerns or questions

What should you take with you when you move?

You should take the following items with you to your new home:

- ⇒ All medications
- ⇒ Complete medical record, including your comprehensive care plan
- ⇒ Personal funds with full accounting
- ⇒ Family or legal representative contact information
- ⇒ Legal papers, such as powers of attorney and advance directives
- ⇒ Personal property with inventory list
 - How will the property be transferred?
 - Who will pay the cost?
 - Will your phone service change?
- ⇒ Identification



What are signs of transfer trauma and how can you mitigate it?

Signs of transfer trauma include:

- *Mood symptoms:* feeling sad, angry irritable, depressed, anxious or tearful
- *Behavior-related symptoms:* combativeness, screaming, complaining, wandering, shutting down, withdrawing, refusing care, isolating, and refusing to take medications
- *Physiological symptoms:* confusion, pain, falling, rapid heartbeat from anxiety, sleeplessness, poor appetite, weight loss or gain, sudden irritable bowel syndrome, indigestion, or nausea

As a family member, you can help prevent transfer trauma by ensuring that residents are involved in the process of selecting their transferring facility and making sure all of their belongings go with them. Try to orient your loved one to their new home. If possible, try to relocate them to a facility where their friends are also going.

Where can you go for help during a nursing home closure?

- Your Local or State Long-Term Care Ombudsman
- Your State's Survey Agency
- Your State's Protection & Advocacy Agency

KNOW YOUR RIGHTS DURING A NURSING HOME CLOSURE

You have the right to:

- Written notice of the closure at least 60 days in advance that also includes the facility's closure plan and where they will be transferring you
- Assurances that you will be transferred to the most appropriate facility or setting with comparable quality, services, and location
- Your needs and choices honored
- An orientation by the facility to prepare you for a safe and orderly transfer
- Contact information for the Long-Term Care Ombudsman Program, who you can call if you have concerns or questions
- Information shared with the receiving provider, such as care plan goals, discharge summary, special instructions, etc.

Make sure you have the following items when you move:

- All medications
- Complete medical record, including comprehensive care plan
- Personal funds with full accounting
- Family or legal representative contact information
- Legal papers, such as power of attorneys and advance directives
- Personal property with inventory list
- Identification

FOR MORE INFORMATION OR TO FIND YOUR LOCAL OMBUDSMAN, CALL (202) 332-2275 OR EMAIL INFO@THECONSUMERVOICE.ORG