STATE of UTAH
LONG-TERM CARE
OMBUDSMAN

Facility-Initiated Transfers and Discharges in Utah

A RESOURCE MANUAL

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Introduction

Discharges which violate federal regulations are of great concern because in some cases they can be unsafe and/or traumatic for residents and their families. These discharges may result in residents being uprooted from familiar settings; termination of relationships with staff and other residents; and residents may even be relocated long distances away, resulting in fewer visits from family and friends and isolation of the resident. In some cases, residents have become homeless or remain in hospitals for months.

Centers for Medicare and Medicaid Services, Memorandum to State Survey Directors, December 22, 2017

Given the potentially devastating physical and psychological harm nursing home discharges can cause, the federal Nursing Home Reform Law and regulations (called Requirements of Participation) permit a facility to transfer or discharge a resident only under certain very limited circumstances. In general, transfers occur when a resident is moved outside the facility and is expected to return; discharges occur when a resident is moved outside the facility, but the resident is not expected to return. In both instances, residents must be given written notice within certain time frames, have the right to appeal, and must be discharged in a safe and orderly way to a location that can meet their needs.

Despite strong protections for residents in the law and regulations, inappropriate and/or illegal facility-initiated discharges still occur. While the exact number of such discharges is not known, CMS estimates that as many as one-third of all residents in long-term care facilities may experience a facility-initiated transfer or discharge.[1] Nationally, complaints regarding nursing facility-initiated discharges have been the most common type of complaint received by the Long-Term Care Ombudsman Program (LTCOP) for the last ten years; for example, in 2020, 8,428 of the 108,648 nursing facility complaints were about discharges.[2]

In Utah, complaints about discharges have been in the top three complaints for the last two years.

(Utah LTCOP data 2020, 2021)

[1] *Facility-Initiated Discharge in Nursing Homes*. Summary prepared by U.S. Department of Health and Human Services Office of Inspector General. https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000331.asp

[2] NORC. 2020 National Ombudsman Reporting System (NORS) data. https://ltcombudsman.org/omb_support/nors/nors-data

Nursing home transfers/discharges, particularly when involuntary, can have serious negative effects on residents. Many residents experience transfer trauma (also referred to as relocation stress syndrome). The response to the stress caused by a transfer or relocation can result in:

- mood symptoms, such as feeling sad, angry, irritable, depressed, distressed, anxious, or tearful;
- changes related to behavior, including withdrawal, refusing care and/or medications, shutting down, agitation;
- physiological symptoms, such as confusion, pain, falls, sleeplessness, poor appetite, and weight loss; and
- increased morbidity and mortality, particularly for residents with dementia.[3]

Since transfers/discharges can have a devastating impact on residents, it is important that they be prevented if at all possible, and be carried out appropriately, safely, and carefully when they do occur. To that end, providers, ombudsmen, and other stakeholders charged with following, enforcing, or advocating for residents under the rules need to fully understand the requirements and guidance around transfer and discharge.

This manual is designed to be a comprehensive resource on nursing home facility-initiated transfers and discharges to settings outside the facility where a resident currently lives.

It does not cover transfers within a nursing home, discharges when a facility is closing, or transfers/discharges that occur in assisted living residences.

Explanation of Regulatory Tools

Requirements of Participation for Long-Term Care Facilities, referred to as federal regulations

Federal nursing home requirements in which the facility must comply to receive funding from the Medicare and/or Medicaid programs.

Centers for Medicare & Medicaid Services (CMS) State Operations Manual (SOM) Appendix PP – Guidance to Surveyors for Long Term Care Facilities

Written guidance from CMS to the state survey agencies about conducting annual surveys and complaint investigations to determine compliance with federal regulations and how to cite for deficient practices under specific tags (i.e., F-Tags).

Continued...

[3] *Prevent Elder Transfer Trauma: Tips to Ease Relocation Stress. Kate Jackson. Social Work Today.* Vol. 15 No. 1 P. 10. January/February 2015 Issue. https://www.socialworktoday.com/archive/011915p10.shtml

This resource is organized into four sections.

1. **SECTION 1: Transfer/Discharge Provisions** is an overview of transfer/discharge provisions. Section 1 provides the state and federal nursing facility laws (when applicable), regulations, definitions, and regulatory tools that pertain to facility-initiated transfers and discharges. In addition to federal regulations, federal regulatory tools include surveyor interpretive guidance, probes and procedures, and key elements of compliance from the Centers for Medicare & Medicaid Services (CMS) State Operations Manual (SOM) Appendix PP – Guidance to Surveyors for Long Term Care Facilities, and critical element pathways (see Explanation of Regulatory Tools).

2. **SECTION 2: Nursing Home Obligations Pertinent To Transfer/Discharge** covers other federal nursing home regulations pertinent to transfer/discharge issues.

3. **SECTION 3: Applying Laws, Regulations, and Regulatory Tools to Address Four Specific Situations** discusses how a range of federal/state laws, regulations, and federal regulatory tools applies to four different situations involving discharges.

4. **SECTION 4: Fair Hearing Process for Resident Appeals of Transfers/Discharges** lays out the general procedures governing the fair hearing process when a resident wishes to appeal a proposed transfer/discharge.

Explanation of Regulatory Tools
continued...

Critical Element Pathways

Developed by CMS, the pathways help direct the surveyor's inspection and identify points to observe, questions to ask, and records to review. They are similar in many ways to guidance.

Investigative Protocols, Procedures, Probes

Information to assist surveyors with actions to take during a survey, including what to look for, ask, and review.

Key Elements of Noncompliance

The main points for surveyors to consider in evaluating a facility's failure to comply with federal regulations.

SECTION 1:

Transfer/Discharge Provisions

How to Read this Section

Each of the transfer/discharge provisions discussed in this section begins with legal citations. In this document, "Federal Regulation" refers to Title 42 of the Code of Federal Regulations (CFR), 42 USC means Title 42 of the United States Code, and "Utah Regulation" refers to the Utah Administrative Code for Health.

- Citations for federal regulations *only* means there are no comparable UT regulations, for example:
  Federal Regulation: 42 CFR § 483.15
- Citations for both federal and UT regulations means these regulations are identical or nearly identical, for example:
  Federal Regulation: 42 CFR § 483.15
  Utah Regulation: R432-150-22

Regulations unique to Utah are indicated in a text box like this.

See **APPENDIX 1: Utah and Federal Regulations Pertaining to Facility-Initiated Transfers or Discharges in Nursing Homes: A Side-by-Side Comparison** for a side-by-side look at federal and Utah regulations pertaining to transfers and discharges.

Types of Nursing Home Certification

Federal Laws: Medicare - 42 USC § 1395i-3 and Medicaid - 42 USC § 1396r

A nursing home can be certified in its entirety, or only partially (a "distinct part"). Common types of nursing home certification include:

- **Skilled Nursing Facility (SNF):** Medicare only certified. These facilities focus on skilled services and short stay rehabilitation.
- **Nursing Facility (NF):** Medicaid only certified. These facilities provide non-skilled care and service to individuals on a long-term basis.
- **Skilled Nursing Facility/Nursing Facility (SNF/NF):** Medicare and Medicaid certified. These facilities may provide skilled service for short stay individuals, as well as care and service to individuals on a long-term basis. This is the most common type of nursing home certification.

A **certified facility** is a nursing home that has contractually agreed to meet federal Requirements for Participation for nursing homes in order to receive Medicare and/or Medicaid funds.

Definition of Transfer or Discharge

Federal Regulation: 42 CFR § 483.5

Transfer and discharge are movement of a resident to a bed **outside** of a certified facility. Movement of a resident to a bed **within** the same certified facility does not constitute transfer or discharge.

A **transfer** refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility when the resident **expects to return to the original facility**.[4]

A **discharge** refers to the movement of a resident from one certified facility to a bed in another certified facility or other location in the community, **when return to the original facility is not expected**.[5]

A transfer or discharge is **facility-initiated** unless the resident takes the initiative and affirmatively wants to leave. The following are situations that are considered to be facility-initiated:[6]

- a resident objects to the transfer or discharge;
- it did not originate through a resident's verbal or written request;
- it is not in line with the resident's goals for care and preferences; or
- it is an emergency transfer to the hospital.[7]

If a resident, or their representative, has provided verbal or written notice of intent to leave the facility, it is considered a **resident-initiated** transfer or discharge.

Resident-Initiated Does Not Include...

- A general expression of the desire to go home or move to the community
- The elopement of a resident with cognitive impairment
- Discharges following completion of skilled rehab when the resident is not in agreement with the discharge even if the resident does not object to the discharge or has not appealed it
- Emergency transfers to the hospital

(State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities)

Utah regulations require each facility to develop written admission, transfer and discharge policies, and make those policies available to the public upon request.
Utah Regulation: R432-150-22

[4] Ctrs. for Medicare & Medicaid Servs., *State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities*, Guidance, 42 CFR § 483.15(c)(2), Definitions, https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf (November 22, 2017).
[5] Id.
[6] Id.
[7] Ctrs. for Medicare & Medicaid Servs., *State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities*, 42 CFR § 483.15(c)(2) Guidance Note, Emergent Transfers to Acute Care, https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf (November 22, 2017).

Permissible Reasons for Transfer or Discharge

Federal Regulation: 42 CFR § 483.15(c)(1)(i)
Utah Regulation: R432-150-22(1)

Once admitted, the facility becomes the resident's home. For this reason, the expectation is that residents should be able to remain except under certain very limited situations.[8] Facilities are expected to take steps so that a facility-initiated transfer or discharge is not necessary. This includes implementing different approaches to care.[9]

A facility may only transfer or discharge a resident for the following **six permissible reasons**.[10]

1. The transfer or discharge is necessary to meet the resident's welfare and the resident's needs cannot be met in the facility.
2. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility.
3. The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident.
4. The health of individuals in the facility would otherwise be endangered.
5. The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Non-payment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay.
6. The facility ceases to operate.

The permissible reasons for transfer or discharge only apply to transfers or discharges initiated by the facility, not by the resident.[11]

[8] Ctrs. for Medicare & Medicaid Servs., *State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities*, Guidance, 42 CFR § 483.15(c)(1)(i) https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf (November 22, 2017).
[9] Ctrs. for Medicare & Medicaid Servs., *State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities*, Investigative Protocol, 42 CFR § 483.15(c)(1)-(2), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf (November 22, 2017).
[10] 42 CFR § 483.15(c)(1)(i).
[11] Ctrs. for Medicare & Medicaid Servs., *State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities*, Guidance, 42 CFR § 483.15(c)(1), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf (November 22, 2017).

A Deeper Dive into the Six Permissible Reasons for Transfer or Discharge

Below is a summary of the **applicable federal guidance, protocols and critical element pathways** for each of the six reasons. Regulations that are pertinent, but not specific to transfer/discharge, are listed following each reason and then described in the section, "Nursing Home Obligations Pertinent to Transfer/Discharge."

REASON #1: The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility.

§ 483.15(c)(1)(i)(A)

Prior to admitting any individual as a resident, the facility must determine its ability to care for that person. The facility is responsible for exercising due diligence when evaluating all potential admissions, taking into consideration other residents currently residing in the facility, as well as staffing levels and competencies. By accepting and admitting a resident, the facility is obligated to ensure the resident receives the necessary care and services to attain and maintain their highest practicable physical, mental, and psychosocial well-being. Therefore, unless the care and service needs of a resident have substantially changed since admission, and the changed needs cannot be met in the facility, a transfer or discharge should not be initiated by the facility.

The Facility Assessment

An evaluation where the facility determines the needs of its resident population and the required resources to provide the care and services the residents need.

(42 CFR § 483.70(e))

In general, a facility must first attempt to meet a resident's needs before stating it can no longer meet those needs and proceeding to transfer or discharge the resident. For instance, if there has been a significant change in the resident's condition, the facility must conduct an assessment of the person to determine if revisions to the care plan would permit the facility to meet the resident's needs before any transfer or discharge action is taken.[12]

Similarly, if the facility believes it cannot meet a resident's needs because of the resident's refusal of care and/or treatment, it must assess the resident and revise the care plan to see if alternative interventions will meet the resident's needs.[13] As part of the reassessment, and to the extent possible, identifying the reason(s) for refusing care and/or treatment may improve opportunities for success moving forward. In addition to providing other options for treatment, the facility must educate the resident on consequences of refusal.[14] Refusal of treatment is a resident's right and is not itself a permissible reason for discharge.[15]

[12] Id.
[13] Id.
[14] *Hospitalization Critical Element Pathway.* Resident, Representative Interview, or Family Interview, CMS-20123.
[15] Ctrs. for Medicare & Medicaid Servs., *State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities*, Guidance, 42 CFR § 483.15(c)(2), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf (November 22, 2017) and 42 CFR § 483.10(c)(6).

The facility must document in the resident's record exactly what needs cannot be met, and what it did to try to meet the resident's needs.[16] It must also indicate what the receiving facility offers that can meet the resident's needs that the transferring/discharging facility cannot.[17] This is particularly important if the receiving facility is also a certified skilled nursing facility or nursing facility because the transferring facility is required to provide the same type and level of services as the receiving facility.

A facility's determination that it cannot meet a resident's needs would also raise questions if the facility has admitted residents with similar needs.[18]

Utah regulations require the facility to prepare a detailed explanation of why the resident's needs could not be met and to include it in the final summary of the resident's status.
Utah Regulation: R432-150-13(5)(b)

See also **SECTION 2: Nursing Home Obligations Pertinent to Transfer/Discharge**

- Resident Rights
- Comprehensive Person-Centered Care Planning (including Discharge Planning)
- Behavioral Health Services
- Disclosure of Special Characteristics or Limitations
- Nursing Services (staffing)
- Training

REASON #2: The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility.

§ 483.15(c)(1)(i)(B)

At times a resident may improve to the point where they do not need nursing home services, but do not want to leave the facility. While this situation is rare, the facility is permitted to pursue a facility-initiated discharge.

Reason #2 for discharge is often erroneously used when a facility believes Medicare coverage will end because the resident no longer qualifies for Medicare skilled services. The end of coverage is assumed to be the end of the resident's stay at the facility. In this situation, the facility has mistakenly conflated "discharge" from Medicare services with "discharge" from the facility. A facility's requirement to notify and explain non-coverage

[16] *Discharge Critical Element Pathway.* Staff Interviews, CMS-20132.
[17] Id.
[18] Ctrs. for Medicare & Medicaid Servs., *State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities*, Guidance, 42 CFR § 483.15(c)(1)(ii), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf (November 22, 2017).

of Medicare Part A services **is separate from and unrelated to** the admission and discharge requirements under 42 CFR §483.15, which outline the notification and other requirements that must be followed in order to discharge an individual from the facility.[19]

The conclusion of Medicare coverage for skilled care does not automatically or necessarily mean the resident no longer needs the services provided by the facility and must leave. A resident may still need nursing home care, wish to receive that care at the facility, and be able to pay for their stay or have their stay paid for by Medicaid or another third-party insurer. These situations would not meet the criteria for discharge under § 483.15(c)(1)(B). Furthermore, a change in payment source from Medicare to private pay or Medicaid is not one of the six permissible reasons for discharge.

In addition, a facility's determination that a resident is no longer eligible for Medicare coverage does not always mean that Medicare services must be discontinued. Residents have the right to several levels of appeal. An appeal ruling may find that the resident still qualifies for Medicare skilled care.

Finally, it is often assumed that residents always want to leave at the end of Medicare reimbursed care. However, discharge following completion of skilled rehabilitation could be involuntary in cases where the resident does not want to leave when Medicare reimbursement ends even if the resident does not object to the termination of Medicare or has not appealed it.[20] As noted above, a resident may wish to continue receiving nursing home care after Medicare coverage has ended (at the conclusion of the 100-day benefit period, for example) or has been discontinued. Because appropriate discharge planning should begin at the time of admission, a sudden discharge should be rare and based on extenuating circumstances.

See also **SECTION 2: Nursing Home Obligations Pertinent to Transfer/Discharge**

- Resident Rights

REASON #3: The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident.

§ 483.15(c)(1)(i)(C)

REASON #4: The health of individuals in the facility would otherwise be endangered.

§ 483.15(c)(1)(i)(D)

Reason #3 applies only in cases where safety is endangered solely as a result of a resident's **clinical or behavioral status**. A transfer or discharge in which the endangerment is due to any other cause would not be permissible.

[19] Ctrs. for Medicare & Medicaid Servs., *State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities*, Guidance, 42 CFR § 483.10(g)(17)-(18), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf (November 22, 2017).
[20] *State Operations Manual, Appendix PP, supra* note 15.

For both Reasons #3 and #4, the facility may consider transferring the resident to an acute care setting. However, unless there is an emergency requiring an immediate transfer, prior to any action, the facility must conduct and document the appropriate assessment to determine if revisions to the care plan would address the safety concern.[21] Those revised approaches should then be implemented and evaluated before any decision about a transfer is made.

There must evidence in the resident's and/or other records that any transfer to the hospital was necessary because the health or safety of individuals was or would have otherwise been endangered.[22]

In the event that a resident is transferred to a hospital or other acute care setting due to a facility's belief that endangerment is occurring, the facility cannot base a subsequent discharge, or a determination not to permit a resident to return during an appeal, on the resident's condition at the time of the transfer.[23] The facility must first fully evaluate the resident after the resident has received treatment.[24] Further, at a minimum, it must make efforts to obtain an accurate understanding of the resident's current status and condition and must find out what treatments, medications, and services were provided by the hospital. There must be evidence of these efforts in the resident's medical record,[25] as well as documentation of how the facility made the determination not to permit the resident to return due to a risk to the health or safety of individuals in the facility.[26]

Additionally, the facility should consider why it is discharging the resident if there are other residents with similar health needs, conditions, or symptoms currently in the facility or who were admitted since the resident was issued a notice of discharge.[27]

Endangering the health or safety of individuals and refusal of treatment

A resident exercising their right to refuse treatment and/or care is not in itself grounds for transfer or discharge.[28] Not all choices that impact a resident's health justify a facility-initiated discharge. Only if the refusal of treatment and/or care poses a risk to the resident's or others' health or safety may a transfer or discharge be considered.[29]

[21] Ctrs. for Medicare & Medicaid Servs., *State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities*, Guidance, 42 CFR § 483.15(c)(1)(i)(3)-(4), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf (November 22, 2017).
[22] *Hospitalization Critical Element Pathway.* Record Review, CMS-20123.
[23] *State Operations Manual, Appendix PP, supra* note 15.
[24] Id.
[25] Ctrs. for Medicare & Medicaid Servs., *State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities*, Investigative Protocol, 42 CFR § 483.15(e), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf (November 22, 2017).
[26] Id.
[27] *State Operations Manual, Appendix PP, supra* note 18.
[28] Ctrs. for Medicare & Medicaid Servs., *State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities*, Guidance, 42 CFR § 483.15(c)(2)(i)(B), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf (November 22, 2017).
[29] Ctrs. for Medicare & Medicaid Servs., *State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities*, Guidance, 42 CFR § 483.15(e), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf (November 22, 2017).

Although a facility may initiate a transfer or discharge for an actual or potential risk to the health or safety of residents or others, the facility must demonstrate, and a physician must document, a bona fide risk. Before the facility proposes to transfer or discharge the resident for this reason, it must first take steps to see if the health or safety concern can be addressed. Those steps include:

- identifying in the care plan the care or service being refused and the risk the refusal poses to the resident, providing information to and educating the resident or resident representative regarding the risks of refusal of treatment,[30] and documenting in the care plan efforts to educate the resident and the representative;
- conducting the appropriate assessment to determine the reason(s) for the refusal of care, including whether a resident who is unable to verbalize their needs is refusing care for another reason (such as pain, fear of a staff member, etc.), and addressing the reason;
- attempting to find alternative means and possible strategies to address the identified risk/need; and
- revising the care plan in a way that would allow the facility to protect the health and safety of others.[31]

If, after taking these steps, the facility is unable to resolve situations where a resident's refusal for care poses a risk to the resident's or others' health or safety, the facility administration, nursing and medical director may wish to convene an ethics meeting, which includes legal consultation, to determine if the facility can meet the resident's needs, or if the resident should be transferred or discharged.[32]

See also **SECTION 2: Nursing Home Obligations Pertinent to Transfer/Discharge**

- Resident Rights
- Comprehensive Person-Centered Care Planning (including Discharge Planning)
- Behavioral Health Services
- Disclosure of Special Characteristics or Service Limitations
- Nursing Services
- Training

REASON #5: The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility.

§ 483.15(c)(1)(i)(E)

Frequently, residents begin their stay paying privately or through a third-party insurer, such as Medicare, but then exhaust their resources or no longer qualify for third party coverage. At that time, the facility must notify the resident of their change in payment status.[33] If the resident wishes to remain at the facility, they must find another source of payment, such as Medicaid.

[30] *State Operations Manual, Appendix PP, supra* note 19.
[31] Id.
[32] Id.
[33] *State Operations Manual, Appendix PP, supra* note 11.

Residents seeking Medicaid funding must apply, and the facility should ensure the resident has the necessary assistance to submit the paperwork (or any other third-party paperwork if other funding is sought).[34]

The resident cannot be discharged for nonpayment if they have applied for Medicaid and their Medicaid eligibility is pending.[35] The resident also cannot be discharged if their initial Medicaid application was denied, and the resident appealed the denial. An appeal suspends a finding of nonpayment.[36]

Conversion from private pay to Medicaid does not constitute non-payment[37] even though the Medicaid rate is lower than the private pay rate.

Sometimes, nonpayment that triggers a discharge may be the result of a misunderstanding or lack of knowledge. This may happen when a resident or resident representative, handling the resident's funds, does not understand the need to pay their bill regardless of the payer source. In this situation, the facility should inform the resident and/or resident representative of the need to pay and the consequences of nonpayment.

At times nonpayment may be due to exploitation or misappropriation of the resident's funds by another person. If there is evidence of exploitation or misappropriation of the resident's funds by the representative, the facility should take steps to notify the appropriate authorities on the resident's behalf, before proceeding to discharge.[38]

See also **SECTION 2: Nursing Home Obligations Pertinent to Transfer/Discharge**

- Resident Rights
- Freedom from Abuse, Neglect, and Exploitation

REASON #6: The facility ceases to operate

§ 483.15(c)(1)(i)(F)

A facility may cease to operate because CMS or the State Medicaid Agency terminates the facility's participation in the Medicare and/or Medicaid programs or because the facility has made the decision to close voluntarily for a number of different reasons, often due to financial difficulties. There are additional federal and state requirements for facility closures that are not covered in this Manual.

See also **SECTION 2: Nursing Home Obligations Pertinent to Transfer/Discharge**

- Administration

[34] Id.
[35] Ctrs. for Medicare & Medicaid Servs., *State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities*, Guidance, 42 CFR § 483.15(a)(4)(i)-(ii), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf (November 22, 2017).
[36] Id.
[37] *State Operations Manual, Appendix PP, supra* note 11.
[38] Id.

Documentation Requirements

Federal Regulation: 42 CFR § 483.15(c)(2)
Utah Regulation: R432-150-22(2)

All facility-initiated transfers and discharges require significant and specific documentation by the facility.

For all permissible circumstances of transfer or discharge, the basis of the transfer or discharge must be documented in the resident's medical record before, or as close as possible, to the actual time of transfer or discharge.[39]

Reason for Transfer or Discharge	Documentation Requirements
The discharge or transfer is necessary for the resident's welfare and the facility cannot meet the resident's needs	The **resident's physician** must document: • information about the basis of the transfer or discharge; • the specific resident needs the facility could not meet; • the facility efforts to meet those needs; and • the specific services the receiving facility will provide to meet the needs of the resident which cannot be met at the current facility.
The resident's health has improved sufficiently so that the resident no longer needs the care and/or services of the facility	The **resident's physician** must document information about the basis of the transfer or discharge.
The resident's clinical or behavioral status (or condition) endangers the safety of individuals in the facility	A **physician** must provide documentation regarding the reason for transfer or discharge.
The resident's clinical or behavioral status (or condition) otherwise endangers the health of individuals in the facility	A **physician** must provide documentation regarding the reason for transfer or discharge.
The resident has failed, after reasonable and appropriate notice to pay, or have paid	The **facility** must document information about the basis of the transfer or discharge.
The facility ceases to operate	The **facility** must document information about the basis of the transfer or discharge.

[39] *State Operations Manual, Appendix PP, supra* note 15.

Information to be Shared with the Receiving Provider

Federal Regulation: 42 CFR § 483.15(c)(2)(iii)

Transfer or Discharge

When a resident is transferred or discharged to another long-term care facility, a hospital, or a mental/behavioral health facility, the nursing home is required to convey specific information to the receiving facility.

This information includes, but is not limited to:

- ☐ contact information of the practitioner responsible for the care of the resident;
- ☐ resident representative information including contact information;
- ☐ advance directive information;
- ☐ all special instructions or precautions for ongoing care, if applicable, including but not limited to:
  - treatments and devices (e.g., oxygen, IVs);
  - precautions (e.g., isolation or contact); and
  - special risks (e.g., falls, elopement, pressure injury);
- ☐ the resident's comprehensive care plan goals;
- ☐ all information necessary to meet the resident's needs, which includes, but may not be limited to:
  - resident status, including baseline and current mental, behavioral, and functional status, reason for transfer, recent vital signs;
  - diagnoses and allergies;
  - medications (including when last received);
  - most recent relevant labs, other diagnostic tests, and recent immunizations; and
- ☐ additional information, if any, outlined in the transfer agreement with the acute care provider.[40]

Discharge

In cases of discharge, nursing homes must also send a discharge summary to the receiving provider. This summary must include, but is not limited to:[41]

- ☐ a summary of the resident's stay, such as diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results;
- ☐ a final summary of the resident's status at the time of discharge that includes the Resident Assessment Instrument (RAI), with the consent of the resident or resident's representative;

[40] Id.
[41] Id.

- ☐ reconciliation of all pre-discharge medications with the resident's post-discharge medications; and
- ☐ a post-discharge plan of care that is developed with the participation of the resident, and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate:
  - where the individual plans to reside;
  - any arrangements that have been made for the resident's follow up care; and
  - any post-discharge medical and non-medical services.

See **APPENDIX 2: Facility-Initiated Transfers or Discharges: Information Required to be Conveyed to Receiving Provider by Transferring/Discharging Provider Checklist** for a checklist of information to be sent to the receiving provider.

Notice of Facility-Initiated Transfer or Discharge

Federal Regulation: 42 CFR § 483.15(c)(3)(i)-(iii)
Utah Regulation: R432-150-22(3)

Persons to be Notified

Before any facility-initiated transfer or discharge, the facility must provide written notice to the resident and the resident representative of the transfer or discharge. The notice must be in a language and a manner they understand. The facility is also required to notify the State Ombudsman of all facility-initiated transfers and discharges.

All facility-initiated transfer and discharge notices and transfer monthly listings must be sent by the facility to the State of Utah Long-Term Care Ombudsman.

EMAIL: **sltcop@utah.gov**
FAX: **801-532-2217**

(Discharge Notification Facility Guidance; State of Utah Long-Term Care Ombudsman Program, https://ltcombudsman.org/uploads/files/support/discharge-utah.pdf)

Notification Time Frames

Federal Regulation: 42 CFR § 483.15 (c)(4)
Utah Regulation: R432-150-22(4)

Time frame in general: At least **30 days** in advance with certain exceptions

Time frame for exceptions: **As soon as practicable**

Exceptions:

- the safety or health of the individuals in the facility is endangered;
- the resident needs urgent medical attention;
- the resident's health improves sufficiently; or
- the resident has not resided in the facility for 30 days.

Transfer/Discharge Notification Breakdown by Type and Time Frame

Unless otherwise indicated, all citations are from 42 CFR § 483.15(c)(3)–(4)

Type of Transfer or Discharge	Resident and Resident Representative Notification	Office of the State Long-Term Care Ombudsman Program Notification via email or fax[42]
Resident-initiated **transfer** or **discharge**	No notification required[43]	No notification required[44]
Facility-initiated **transfer**	Written notice at least **30 days before** the transfer Written notice of facility's bed-hold policy upon transfer[45]	In a monthly listing[46]
Facility-initiated **transfer** when the safety or health of the individuals in the facility is endangered, if the resident needs urgent medical attention (an "emergency"[47] transfer), if the resident's health improves sufficiently, or the resident has not resided in the facility for 30 days	Written notice **as soon as practicable before** the transfer Written notice of facility's bed-hold policy upon transfer or within 24 hours[48]	In a monthly listing[49]

[42] *Discharge Notification Facility Guidance*; State of Utah Long-Term Care Ombudsman Program, https://ltcombudsman.org/uploads/files/support/discharge-utah.pdf
[43] Ctrs. for Medicare & Medicaid Servs., *State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities*, Guidance, §483.15(c)(3)-(6), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf (November 22, 2017).
[44] Id.
[45] Ctrs. for Medicare & Medicaid Servs., *State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities*, Guidance, §483.15(d)(2), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf (November 22, 2017).
[46] Ctrs. for Medicare & Medicaid Servs., *State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities*, Guidance, §483.15(c)(4), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf (November 22, 2017).
[47] Id.
[48] Ctrs. for Medicare & Medicaid Servs., *State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities*, Guidance, §483.15(d)(2), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf (November 22, 2017).
[49] *State Operations Manual, Appendix PP, supra* note 46.

Type of Transfer or Discharge	Resident and Resident Representative Notification	Office of the State Long-Term Care Ombudsman Program Notification via email or fax[42]
Facility-initiated **discharge** (including a facility-initiated discharge while the resident is in the hospital or on therapeutic leave[50])	Written notice at least **30 days before** the date of discharge	A copy of the resident's written notice at least **30 days before** the date of discharge (at the same time issued to the resident)[51]
Facility-initiated **discharge** when the safety or health of the individuals in the facility is endangered, if the resident needs urgent medical attention, if the resident's health improves sufficiently, or the resident has not resided in the facility for 30 days	Written notice **as soon as practicable** before the date of discharge	A copy of the resident's written notice **as soon as practicable before** the date of discharge (at the same time issued to the resident)[52]
Changes to the facility-initiated **transfer** or **discharge** notice[53]	**As soon as practicable** prior to initiating any change[54]	**As soon as practicable** prior to initiating any change (at the same time issued to the resident)[55]
Significant changes to the facility-initiated **transfer** or **discharge** notice[56] (e.g., change in destination)	A **new 30-day written notice** must be given that clearly describes the change(s) and resets the transfer or discharge date[57]	A copy of the resident's **new 30-day written notice** (at the same time issued to the resident)[58]

See **APPENDIX 3: Discharge Notification Facility Guidance State of Utah Long-Term Care Ombudsman Program** for further information.

[50] 42 CFR § 483.15(e)(1)(ii)
[51] *Discharge Notification Facility Guidance; supra* note 43.
[52] *State Operations Manual, Appendix PP, supra note* 43.
[53] 42 CFR § 483.15(c)(6)
[54] Id.
[55] *State Operations Manual, Appendix PP, supra* note 43.
[56] Ctrs. for Medicare & Medicaid Servs., *State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities*, Guidance, 42 CFR § 483.15(c)(6), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf (November 22, 2017).
[57] Id.
[58] *State Operations Manual, Appendix PP, supra* note 43.

Required Contents of a Transfer or Discharge Notice

Federal Regulation: 42 CFR § 483.15 (c)(5)
Utah Regulation: R432-150-22(6)

The notice must include:

- ☐ the specific reason for the transfer or discharge, including the basis per § 483.15(c)(1)(i)(A)-(F);
- ☐ the effective date of transfer or discharge;
- ☐ the location to which the resident is to be transferred or discharged;
- ☐ an explanation about the resident's appeal rights, including:
  - the name, address (mailing and email) and telephone number of the entity which receives appeal hearing requests;
  - information about how to request an appeal hearing;
  - information about how to obtain assistance in completing the appeal form and submitting the appeal hearing request;
- ☐ the name, address, (mail and email) and telephone number of the Office of the State Long-Term Care Ombudsman and the local ombudsman; and
- ☐ the name, mail and e-mail addresses and phone number of the state protection and advocacy agency responsible for advocating for residents with intellectual and developmental disabilities and/or a mental disorder.

See **APPENDIX 4: Sample Notice of Transfer or Discharge** for a template of notice requirements.

Orientation of the Resident for Transfer or Discharge

Federal Regulation: 42 CFR § 483.15(c)(7)
Utah Regulation: R432-150-22(7)

A nursing facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. Orientation must be provided in a form and manner that the resident can understand and must be documented in the resident's record.

Sufficient preparation and orientation mean the facility informs the resident where they are going and takes steps to minimize anxiety. When determining the form and manner of orientation and preparation, the facility must take into consideration factors that may affect the resident's ability to understand, such as educational level, language and/or communication barriers, and physical and mental impairments. The facility must include documentation about the resident's understanding of the transfer or discharge in the resident's record.[59]

[59] 42 CFR § 483.15(c)(7)

Example

Mrs. Smith is having a heart attack and is waiting for the ambulance. She said she's scared. She doesn't know why they can't treat her at the facility and does not want to go to the hospital. To minimize her anxiety, a facility staff member, Brian, tells Mrs. Smith the hospital has all the resources she needs to help her get better. Brian told Mrs. Smith her daughter has been notified and will be at the hospital when Mrs. Smith arrives. Brian reassures Mrs. Smith she will come back to the facility as soon as the doctor says it is safe to do so.

In the example above, the staff member eases the resident's anxiety about the emergency transfer to the hospital by letting her know her needs will be met at the hospital, she will not be alone when she gets to the hospital, and she will be able to come back to the facility.

Notice of Bed-Hold Policy and Return

Federal Regulation: 42 CFR § 485.15(d)
Utah Regulation: R432-150-22(8)

All facilities are required to have a written bed-hold policy that addresses a resident's absence from the facility due to hospitalization or therapeutic leave.

Therapeutic Leave

Absences for purposes other than required hospitalization.

(State Operations Manual, Appendix PP - Guidance to Surveyors for Long Term Care Facilities)

The policy must address:

- the duration of the facility's bed-hold for all residents;
- how long, if at all, the State will pay to reserve a bed for a resident whose stay is covered by Medicaid;[60] and
- the conditions upon which the resident can return to the facility.

Utah State Medicaid does not pay to hold a bed for residents whose stay is paid by Medicaid when they are hospitalized. State Medicaid will pay for bed-hold during therapeutic leave.

Facilities must issue two notices regarding bed-hold policies. **The first notice** must be provided to **all residents** (regardless of payment source) or their representatives in advance of a transfer, usually provided as part of the admission packet.[61]

[60] *Utah Medicaid Provider Manual*, Division of Medicaid and Health Financing, Long Term Care Services, Updated April 2018

[61] Ctrs. for Medicare & Medicaid Servs., *State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities*, Guidance, 42 CFR § 483.15(d) https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf (November 22, 2017).

Upon a transfer, **a second bed-hold notice** must be given to the resident being transferred and the resident representative. If providing notice at the time of transfer is not possible due to a medical emergency, notice must be provided as soon as possible, but not more than 24 hours after the transfer. In cases where the facility is unable to notify the resident's representative, the facility is expected to make multiple attempts to reach the representative and to document those attempts. [62]

Bed-Hold

Holding or reserving a resident's bed while the resident is absent from the facility for therapeutic leave or hospitalization.

(State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities)

Because neither Medicare nor Medicaid covers the cost of bed-holds, facilities may allow residents to pay privately to hold their bed. In addition, residents not covered by Medicare or Medicaid may also privately pay to hold a bed.

UT regulation requires that notice of the resident bed-hold policy, transfer and re-admission be documented in the resident file.
Utah Regulation: R432-150-22(8)

Permitting Residents to Return to the Facility

Federal Regulation: 42 CFR § 483.15 (e)(1)
Utah Regulation: R432-150-22(8)(d)

Facilities must have and follow a written policy on permitting residents to return to the facility after hospitalization or therapeutic leave, regardless of their source of payment.

Residents have the right to return to a facility when they continue to require nursing facility services, and if eligible for Medicare or Medicaid coverage of their nursing home care. This right applies even when:

Unlike other residents' rights, the right to return to the facility after a hospitalization or therapeutic leave only applies to Medicaid and Medicare eligible residents.

- their hospitalization or therapeutic leave has exceeded the specified bed-hold;
- no bed-hold was available, or
- the resident/representative chose not to request a bed-hold. [63]

[62] Ctrs. for Medicare & Medicaid Servs., *State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities*, Guidance, 42 CFR § 483.15(d)(2) https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf (November 22, 2017).
[63] Id.

Residents can return to their previous room, if available. Otherwise, the resident must be admitted to the next available bed in a semi-private room.[64] The facility must permit Medicaid-eligible residents to return to their previous room if available or, if not, the first available bed even if the resident has an outstanding Medicaid balance.[65] Residents who pay privately when returning from a hospitalization (or therapeutic leave) do not have this right.

When Returning to the Facility is in Question

Sometimes a facility's concerns about permitting a resident to return to the facility are due to the resident's clinical or behavioral condition at the time of transfer. However, this is not a valid reason for denying a resident the right to come back because the decision cannot be based on the resident's condition at the time of transfer to the hospital.[66]

There must be evidence in the resident's record that the resident's present condition and status have been evaluated. This includes obtaining an accurate status of the resident's current condition and learning what treatments, medications, and services the hospital provided to improve the resident's condition.

If the facility determines that the resident who was transferred should not return, **the transfer becomes a facility-initiated discharge**. The reason for the discharge must be one of the 6 permissible reasons cited in § 483.15 (c)(1) **and the facility must meet all facility-initiated discharge requirements**.

Right to Remain in or Return to the Facility Pending Appeal

Federal Regulation: 42 CFR § 483.15(c)(1)(ii)

Right to Remain

A resident who has filed an appeal of the facility's decision to transfer or discharge them has a right to remain in the nursing home pending the results of the appeal unless the failure to discharge the resident poses a danger to the health or safety of the resident or others in the facility. The facility is required to document the danger that remaining in the facility during the appeal would pose.

Right to Return

When a resident is in a hospital or mental/behavioral health facility or on therapeutic leave and has filed an appeal of a transfer or discharge, the facility is required to accept the resident back unless there is evidence that the resident's return would endanger the health or safety of the resident or other individuals in the facility.[67]

[64] *A Closer Look at the Revised Nursing Facility Regulations: Return to Facility After Hospitalization*. Factsheet. Center for Medicare Advocacy, Justice in Aging, National Consumer Voice for Quality Long-Term Care.
[65] *State Operations Manual, Appendix PP, supra* note 25.
[66] Id.
[67] *State Operations Manual, Appendix PP, supra* note 11.

Example

A resident strikes out at staff and other residents and is sent to the hospital. The facility says because the resident was endangering others, it will not take the resident back and issues a notice of discharge. The resident appeals and wants to return to the facility pending the appeal. The facility refuses, stating that the resident is a danger to others. While in the hospital, the resident received treatment, has shown no signs of striking out or endangering others, and has a doctor's order for discharge back to the nursing home. Because there is no evidence that the resident continues to be a danger to self or others, the facility must permit the resident to come back until an appeal decision has been made.

Key Points Pending an Appeal

Unless the facility can prove a resident is a danger to their health or safety or that of others:

- residents have a right to remain in the facility while a discharge is being appealed; and
- residents have a right to return to the facility from the hospital or a mental/behavioral health facility and stay during the appeal process.

SECTION 2:

Nursing Home Obligations Pertinent To Transfer/Discharge

This section discusses federal nursing home requirements that impact transfers/discharges, including federal guidelines, protocols, and critical element pathways when applicable. These regulations are significant because, when not followed, situations may result that might lead a facility to initiate a transfer or discharge that could be prevented.

Resident Rights

Refusal of Treatment

Federal Regulation: 42 CFR § 483.10(c)(6)

The resident has the right to refuse and/or discontinue treatment.

How does this regulation apply to transfers/discharges?

A facility cannot transfer or discharge a resident simply because they refuse treatment or care. Transfer or discharge is only permitted if the refusal poses a danger to the health or safety of individuals in the facility, and then only after the facility has taken the steps in Section 1, Reasons #3 and #4, including assessing the resident, revising the care plan, and implementing alterative means to address the identified risk or need.

Reasonable Accommodation of Needs and Preferences

Federal Regulation: 42 CFR § 483.10(e)(3)

The resident has the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.

Right to Self-Determination

Federal Regulation: 42 CFR § 483.10(f)(1)-(3) and 42 CFR § 483.10(f)(8)

The resident has a right to:

- choose activities, schedules, health care, and health care providers consistent with their interests, assessments, and plan of care;
- make choices about aspects of their life in the facility that are significant to them; and
- interact with members of the community and participate in social, religious, community and other activities both inside and outside the facility that do not interfere with the rights of other residents in the facility.

How do these regulations apply to transfers/discharges?

Often proposed transfers or discharges, particularly those stating the facility cannot meet the resident's needs or the resident is endangering the safety of others, stem from a resident's actions or expressions of distress. Such actions/expressions can result when facility practices do not honor or accommodate a resident's routines and preferences.

Example

A resident living with dementia may lash out at staff when they try changing her in the mornings because they come in so early that the resident, who has always slept later into the morning, is abruptly woken from a deep sleep.

When this occurs repeatedly, the facility may regard the resident as a danger to others and proceed to discharge her instead of recognizing that the actions are the result of the resident's preferences and choice of schedules not being upheld. The resident may stop lashing out if her preferences are accommodated by facility staff and reflected through adjustments in the care plan.[68]

Right to be Informed

Federal Regulation: 42 CFR § 483.10(g)(1)

The resident has the right to be informed of their rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility.

How does this regulation apply to transfers/discharges?

The facility has a duty to ensure that the resident and the resident representative is informed of resident responsibilities. This information must be provided in a language and format residents and/or resident representatives understand and communicated as appropriate during the resident's stay.

Example

Facility staff found medical cannabis in a resident's bedside drawer and issued a notice of discharge for endangering others, claiming other residents could have access to the cannabis. However, the facility never informed the resident of their policy to report any and all prescribed and over the counter medications to the facility.

[68] 42 CFR § 483.10(f)(1)-(3), (8).

Right to be Informed of Charges

Federal Regulation: 42 CFR § 483.10(g)(18)

The facility must inform each resident of any charges for services not paid for by Medicare/Medicaid or by the facility's per diem rate, so they know what is/isn't being covered. If there are any changes in what Medicare and/or Utah Medicaid will pay for, the facility must notify residents of those changes as soon as possible.

How does this regulation apply to transfers/discharges?

Far too often a notice of change in services and items covered under Medicare is misinterpreted as a notice of discharge from the facility. Under this regulation, the facility must provide written notice to the resident when Medicare coverage will be changing - including when coverage will end.

There are two types of notices related to a change in Medicare coverage: the Notice of Medicare Noncoverage (NOMNC) and the Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN).

When the facility believes that Medicare coverage for the resident is no longer medically necessary, it must give the resident a Notice of Medicare Non-Coverage (NOMNC) at least two days before Medicare will end. The resident can try to keep Medicare-covered services in place, without any interruption in coverage and Medicare payments, by appealing to the Quality Improvement Organization.

In addition, the facility must give the resident a Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) whenever it believes that Medicare will not pay for the resident's stay. One of the circumstances requiring a SNFABN occurs when the facility takes steps to end a resident's Medicare coverage. Facilities must give residents both the NOMNC and the SNFABN when they believe Medicare will not pay for the resident's continuing care.

> The NOMNC and the SNFABN are not notices of discharge from the facility. **They are separate from and unrelated to** discharge requirements under 42 CFR § 483.15, which outline the notification and requirements under which an individual may be discharged from the facility.

Freedom from Abuse, Neglect, and Exploitation

Federal Regulation: 42 CFR § 483.12

The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation.

Federal Regulation: 42 CFR § 483.12(a)(5)(A)-(B)

The facility must report to the State Agency and one or more law enforcement entities any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility. The report shall occur immediately, but not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury.[69]

Federal Regulation: 42 CFR § 483.12(c)(1)

The facility must report an allegation of possible exploitation to the State Survey Agency (i.e., Utah Department of Health and Human Services) and Adult Protective Services immediately, but not later than 24 hours after the alleged exploitation has occurred.

How do these regulations apply to transfers/discharges?

In cases of non-payment, the resident representative responsible for paying the facility out of the resident's funds or another individual may be financially exploiting the resident. The representative/other person may be illegally or improperly using the resident's money for their personal use. If not addressed, the resident – through no fault of their own – may end up owing the facility a considerable amount of money.

Facilities must ensure that residents are free from exploitation. Since financial exploitation is a crime in Utah[70], and a violation of nursing home regulations, facilities are required to report to multiple entities. Facilities suspecting any resident is being financially exploited must report this concern to the Utah Department of Health and Human Services. In addition, facilities must report:

- a suspected crime to law enforcement; and
- an alleged violation to Adult Protective Services.

Because this reporting could result in investigations that might stop the exploitation, and therefore the nonpayment, the facility should fulfill its reporting mandates prior to issuing a discharge notice.[71]

See **Section 3, Situation 4** about financial exploitation involving family members or others outside the facility.

Special Characteristics or Service Limitations of the Facility

Federal Regulation: 42 CFR § 483.15(a)(6)

The facility must inform residents or potential residents of any special characteristics or service limitations prior to admission.

[69] *Enhancing Your Advocacy Toolbox: Protecting Residents from Nursing Facility-Initiated Discharges*. National Long-Term Care Ombudsman Resource Center. January 2021.
[70] Utah Criminal Code, Offenses Against the Person, Assault and Related Offenses, Abuse, neglect, or exploitation of a vulnerable adult 76-5-111(2) & (3)
[71] *State Operations Manual, Appendix PP, supra* note 11.

How does this regulation apply to transfer/discharge?

When a facility provides special care or services above and beyond federal requirements for nursing facilities (e.g., a mechanical ventilation unit),[72] it means a facility has the ability and capacity to provide care for individuals with those particular needs. A proposed discharge because the facility later believes it cannot meet the resident's needs due to symptoms or care requirements related to its stated areas of specialty would be contrary to the facility's own claims.

> A facility must provide all services and care required under its license and certification. A facility cannot identify any required services and care as a service limitation that it does not provide.
>
> (State Operations Manual, Appendix PP, Guidance, 42 CFR § 483.15(a)(6))

Example

A facility states that it has a ventilator unit. It cannot discharge a resident on a ventilator because they have anxiety, become agitated frequently, and need additional care and attention. Anxiety and agitation are common with individuals who are on a ventilator and responding to this distress is part of care that must be provided on the unit.

At the same time, if a facility does not disclose any limitations in its ability to care for residents with specific diagnoses or medical conditions, it is indicating its ability and capacity to provide the range of care and services that someone with those diagnoses or medical conditions must receive.

Assessment and Care Planning

Federal Regulation: 42 CFR § 483.20(b)(1)

The facility must conduct a comprehensive assessment of a resident's needs, strengths, goals, life history, and preferences. This includes assessing the resident's customary routines, physical and cognitive functioning, communication, mood and behavior patterns, health conditions, and more. As part of the assessment process, staff must observe and speak with the resident, as well as with direct care staff from all shifts.[73] The assessment must be conducted using the resident assessment instrument (RAI), a tool specified by CMS.

[72] Ctrs. for Medicare & Medicaid Servs., *State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities*, Guidance, 42 CFR § 483.15(a)(6), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf (November 22, 2017).
[73] 42 CFR § 483.20.

Federal Regulations: 42 CFR § 483.20(b)(2); 42 CFR § 483.20(c)

An assessment must be completed within 14 days of a resident's admission, after a significant change in the resident's physical or mental status, and at least annually. A facility is also required to conduct a less-detailed quarterly assessment for each resident.

Significant change: A major decline or improvement in the resident's status that requires further intervention by staff or clinical interventions to resolve itself, has an impact on more than one area of the resident's health status, or requires interdisciplinary review or revision of the care plan, or both.

(42 CFR §483.20(b)(2)(ii))

Significant Change Examples

- Presence of a symptom of distress not previously reported by the resident or staff and/or an increase in the frequency of the symptom
- Changes in frequency or severity of behavioral symptoms of dementia that indicate progression of the disease process since the last assessment
- Beginning use of a restraint of any type when it was not used before

(State Operations Manual Appendix PP, Guidance §483.20(b)(2)(ii))

Comprehensive Person-Centered Care Planning

Federal Regulation: 42 CFR § 483.21(b)

Within 7 days of completing the comprehensive assessment, the facility must develop and implement a comprehensive person-centered care plan. The purpose of the care plan is to identify objectives, time frames, and services to be provided for meeting the resident's needs identified in the comprehensive assessment. This includes a resident's medical, nursing, mental, and psychosocial needs.

The comprehensive care plan must:

- Be person-centered
- Identify specific and appropriate interventions
- Be carried out consistently

The care plan must be reviewed and revised after each assessment, including both the comprehensive and quarterly review assessments.[74]

How do these regulations apply to transfers/discharges?

One common reason facilities give to initiate a transfer or discharge is that the facility can't meet the resident's needs. Proper assessments, reassessments, and a comprehensive care plan are all key to meeting a resident's needs.

[74] 42 CFR §483.21(b)

Proper care planning includes addressing a resident's medical, nursing, mental, and psychosocial needs, as well as other aspects of a resident's care and well-being. If each of the provisions related to care planning has not been followed, it would be premature to conclude that the resident's needs cannot be met in the facility.

A resident's condition or safety concerns posed by the resident may also trigger a proposed transfer/discharge. In these situations, the facility must comprehensively assess the physical, mental, and psychosocial needs of the resident to identify these concerns and/or to determine underlying causes.[75] The facility should then revise the care plan incorporating different interventions, with input from the resident. This care plan should be implemented consistently across all shifts to determine if these changes will address the concerns, meet the resident's needs, and eliminate the reason for discharge.

If the facility believes it cannot meet a resident's needs because of the resident's refusal of care or treatment, it must do more than document the refusal in the resident's records. The facility must assess the resident and revise the care plan to see if those steps address the concerns. In addition to providing other options for treatment, it must educate the resident on consequences of refusal. Refusal of treatment itself is not a permissible reason for discharge.[76]

Discharge Planning

Federal Regulation: 42 CFR § 483.21(c)(1-2)

A facility is required to have a discharge planning process that must:

- identify each resident's discharge goals and needs, and develop and implement interventions to address the resident's identified goals and needs;
- involve the interdisciplinary team, the resident, and the resident representative; and
- consider caregiver/support person availability, and the resident's or caregiver's/support person's(s') capacity and capability to perform required care.

When discharge is anticipated, the facility must prepare a discharge summary for the resident that includes a post-discharge plan of care.

The post-discharge plan of care must indicate where the individual plans to reside and any arrangements that have been made for:[77]

- follow-up care the resident will receive from other providers and the providers' contact information;
- medical and non-medical services;
- medical equipment, if necessary; and
- community care and support services, if needed.

[75] *Hospitalization Critical Element Pathway*, Critical Element Decisions CMS-20123.
[76] *State Operations Manual, Appendix PP, supra* note 11.
[77] 42 CFR § 483.21(c)(2)(iv)

How do these regulations apply to transfers/discharges?

Discharge planning must ensure that the resident's health and safety needs, as well as preferences, are met and identify the discharge destination.[78] If a facility proposes a discharge to a setting where a resident's welfare and safety could be at risk, such as a homeless shelter or motel, the discharge would not be in accordance with the requirements of the discharge planning process. Such locations would not have staff available to provide care, services, and supervision as necessary.

Further, the discharge would not be appropriate if it did not include a post-discharge plan that addresses the resident's needs after discharge.

Key Points to Discharge Planning

The discharge planning process must result in a discharge plan that meets the needs of, and is appropriate for, the resident. An inadequate discharge planning process may complicate the resident's recovery, lead to admission to a hospital, or even result in the resident's death.[79]

Nursing Services

Federal Regulation: 42 CFR § 483.35

The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The number and kind of staff and the competencies and skills needed are determined by the assessments and care plans of individual residents and by the facility assessment.

[78] *State Operations Manual, Appendix PP, supra* note 11
[79] Id.

What It Means to Have Sufficient and Competent Staff

Procedures and Probes: 42 CFR § 483.35(a)(3)-(4) & (c)

Sufficient Staff	Enough nursing staff to provide necessary care and services to residents and enough licensed nurses to assist and monitor aides
	Nursing staff responsive to residents' requests for assistance, including responsiveness of staff so there are no pungent odors, residents calling out, or residents wandering with inadequate supervision
	Frequent checks (e.g., each half hour) on residents who are unable to use call bells or otherwise communicate their needs for safety, comfort, bathroom needs, positioning, and offering fluids and other provisions of care
	Residents and families who feel they can have a conversation with a nursing staff member without feeling rushed
	The facility filling positions in a timely manner (e.g., within 1 hour after the start of the shift) when there are staff call-outs
Competent Staff	Staff with competencies in the following areas: resident rights, person-centered care, communication, basic nursing skills, basic restorative services, skin and wound care, medication management, pain management, infection control, cultural competency, and identification of changes in condition
	Staff understand and follow current standards of practice (e.g., if the resident requires a manual lift for transferring, staff demonstrate knowledge and skill in the proper use of the lift and perform the activity in a safe manner)
	Staff with skills and techniques necessary to carry out a resident's care plan

How does this regulation apply to transfers/discharges?

The issues leading to a proposed transfer/discharge may be the result of inadequate staffing levels and/or staff who do not have adequate skills and techniques to care for a resident. However, since the nursing home is required to have enough qualified nursing staff to provide the necessary care and services to a resident in accordance with their care plan and to respond to each resident's needs, lack of enough staff or competent staff would not be an acceptable argument for proceeding with discharge.

Behavioral Health Services

Federal Regulation: 42 CFR § 483.40

The facility must provide behavioral health services so each resident can reach their highest possible level of functioning and well-being.[80] The facility must also provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.[81]

Residents who display or are diagnosed with mental disorder or psychosocial adjustment difficulty, or who have a history of trauma and/or post-traumatic stress disorder, must receive treatment and services to correct the assessed problem or to attain the highest level of mental and psychosocial well-being.[82]

Residents who do not display or are not diagnosed with mental disorder or psychosocial adjustment difficulty, or who do not have a history of trauma and/or post-traumatic stress disorder, should not show decreased social interaction or increased withdrawn, angry or depressive behaviors unless it is clinically unavoidable.[83]

A resident who displays or is diagnosed with dementia, must receive the appropriate treatment and services to attain or maintain their highest practicable physical, mental, and psychosocial well-being.[84]

How do these regulations apply to transfers/discharges?

Many proposed transfers or discharges are triggered by issues related to behavioral health. The behavioral health services requirements are designed to help meet the behavioral needs of residents and attain or maintain their highest level of functioning and well-being.

Before proceeding with any discharge related to a resident's actions or expressions of distress, the facility must make comprehensive efforts to provide the necessary behavioral health care and services to the resident.

The facility's actions should include, but not be limited to:

- developing and using individualized person-centered interventions based, at a minimum, on the resident's diagnosed conditions, history, prior level of functioning, and response to stressors;
- ensuring the resident receives necessary services for behavioral health care needs; and
- revising behavioral care plans when they are not working or when there has been a change in the resident's condition or status.[85]

[80] 42 CFR § 483.40
[81] 42 CFR § 483.40(d)
[82] 42 CFR § 483.40(b)(1)
[83] 42 CFR § 483.40(b)(2)
[84] 42 CFR § 483.40(b)(3)
[85] Ctrs. for Medicare & Medicaid Servs., *State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities*, Key Elements of Noncompliance, 42 CFR § 483.40, https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf (November 22, 2017).

It would be inappropriate to initiate transfer/discharge without first ensuring these steps have been taken.

Sufficient Staff to Provide Behavioral Health Services

Federal Regulation: 42 CFR § 483.40(a)(1)-(2)

The facility must have sufficient staff with appropriate competencies and skills to provide direct behavioral health care and services to residents, keep residents safe, and help each resident reach their highest level of well-being.

The number and kind of staff and the competencies and skills needed are determined by the assessments and care plans of individual residents and by the facility assessment (i.e., an evaluation of facility resources, including staff competencies, that are necessary to provide the level and types of care needed for the resident population).[86] These competencies and skills sets include knowledge of and appropriate training and supervision to care for residents with mental and psychosocial disorders and residents with a history of trauma and/or post-traumatic stress disorder, as well as implementing non-drug interventions.[87]

How does this regulation apply to transfers/discharges?

A facility must provide sufficient staff who have the knowledge, training, competencies, and skills set to address the behavioral health care needs of each resident. This includes preventing resident distress or implementing appropriate interventions when a resident expresses or indicates distress.

A facility proposing to transfer/discharge a resident due to actions or expressions of distress would first need to do the following:

- rule out underlying causes for the resident's behavioral health care needs through assessment, diagnosis, and treatment;
- identify competencies and skills sets staff need to work effectively with residents with mental disorders and other behavioral health needs;
- provide sufficient staff who have the knowledge, training, competencies, and skills sets to address behavioral health care needs;
- make reasonable efforts to obtain professional health services for a resident when needed, and document attempts to access such services;

[86] Ctrs. for Medicare & Medicaid Servs., *State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities*, Investigative Protocol, 42 CFR §483.40(a), (a)(1)- (a)(2), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf (November 22, 2017).
[87] 42 CFR § 483.40(a)

- ☐ use non-drug approaches to care. These approaches should be based upon the comprehensive assessment, consistent with the resident's abilities, customary daily routine, life-long patterns, interests, preferences, and choices;
- ☐ monitor and continually assess the resident's behavioral health needs to determine if the interventions are improving or stabilizing the resident's status or causing adverse consequences;
- ☐ attempt alternate approaches to care if necessary; and
- ☐ accurately document all relevant actions in the resident's medical record.[88]

Administration – Facility Assessment

Federal Regulation: 42 CFR § 483.70(e)

The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies.

The facility assessment must address or include:

- the facility's resident population, including:
  - the number of residents;
  - the care required by the residents, taking into consideration the types of diseases, conditions, physical and cognitive disabilities, and overall acuity;
  - staff competencies needed to provide the level and types of care needed; and
  - any ethnic, cultural, or religious factors that may possibly affect the care provided by the facility;
- the facility's resources, such as buildings, equipment, services, and personnel; and
- a facility-based and community-based risk assessment, utilizing an all-hazards approach (i.e., an approach that considers a wide range of emergencies or disasters).

See Facility Assessment § 483.70(e) regarding determination of the level of sufficient staffing needed and competency-based approach to determine the knowledge and skills required among staff.

The facility must review and update the assessment as necessary, at least annually, and whenever there is, or the facility plans for, any change that would require a major change to any part of the assessment.

[88] Ctrs. for Medicare & Medicaid Servs., *State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities*, Key Elements of Noncompliance, 42 CFR §483.40(a), (a)(1)-(a)(2), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf (November 22, 2017).

How does this regulation apply to transfers/discharges?

The facility assessment is the foundation for determining staffing levels and competencies. It must include an evaluation of the overall number of facility staff needed to ensure a sufficient number of qualified staff are available to meet each resident's needs.[89] A proposed discharge of a resident for the inability to meet a resident's needs due to a lack of staffing or staff who do not have the knowledge and skills to provide care to the resident would therefore not be an appropriate reason for discharge.

Further, facilities are required to determine their capacity and capability to care for the individuals they admit. As a result, facilities should not admit residents whose needs they cannot meet based on the facility assessment.[90] Admitting a resident means the facility has determined it is capable of meeting the individual's needs. For this reason, a discharge for the inability to meet the resident's needs should only occur if the resident's needs have changed to either not require the services provided or exceed the licensing and certification requirements.

Training Requirements

Federal Regulation: 42 CFR § 483.95(a)-(f) & (i)

A facility must develop, implement, and maintain an effective training program for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers based on their roles. The amount and types of training are determined by the facility based on its facility assessment.

Training topics must include, but are not limited to:

- communication;
- resident's rights and facility responsibilities;
- abuse, neglect and exploitation, including dementia management;
- quality assurance and performance improvement;
- infection control;
- compliance and ethics; and
- behavioral health.

[89] Ctrs. for Medicare & Medicaid Servs., *State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities*, Guidance, 42 CFR §483.40(e), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf (November 22, 2017).
[90] State Operations Manual, Appendix PP, supra note 8.

Training for Nurse Aides

Federal Regulation: 42 CFR § 483.95(g)

In-service training for nurse aides is required. Training must be sufficient to ensure nurse aides continue to be competent but must be no less than 12 hours per year. It must address areas of weakness identified in nurse aides' performance reviews and the facility assessment. Among the required topics are dementia management training, resident abuse prevention training, and care of residents with cognitive impairments if the nurse aide provides services to residents who are cognitively impaired.

How do these regulations apply to transfers/discharges?

The facility is responsible for ensuring staff receive sufficient and proper training in delivering the care required to meet the needs of each resident. This includes effective training for all staff in a range of topics. Before considering a discharge, a facility should first ensure that it has provided adequate, appropriate, and required training to all staff caring for the resident.

SECTION 3:

Applying Laws, Regulations, and Regulatory Tools to Address Four Specific Situations

In Utah and around the country, nursing home residents have faced some particularly challenging transfer/discharge situations.

This section presents four such situations:

- transfer/discharge to an unsafe and/or inappropriate location;
- refusal to permit a resident to return to the facility;
- discharge due to termination of Medicare coverage; and
- financial exploitation.

For each scenario, key provisions that apply to these situations are identified and include:

- relevant nursing home regulations;
- federal guidance, investigative protocols, critical element pathways, other regulatory process/procedures; and
- pertinent non-nursing home laws.

1 SITUATION #1: Transfer or Discharge to an Unsafe and/or Inappropriate Location

There are times when the location to which the resident is to be transferred or discharged will not meet the needs of the resident, is unsafe, or is inappropriate. Such locations may include a homeless shelter, the street, a motel, or a home in the community without proper services or caregivers available and willing to care for the resident.

A range of regulations, laws, and guidance requires facilities to ensure that residents are transferred or discharged to a setting where they will be safe and receive the necessary care and services to meet their needs.

The Transfer/Discharge Itself Must Be Safe and Orderly

Federal Regulation: 42 CFR § 483.15(c)(7)
Utah Regulation: R432-150-22(7)

The facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer. Preparation and orientation must be provided in a manner the resident can understand.

Discharge Planning Must Meet the Resident's Discharge Care Needs and Ensure a Smooth, Safe Transition

Federal Regulation: 42 CFR § 483.21(c)

Discharge planning is the process of creating an individualized discharge care plan. The plan is developed by the interdisciplinary team, the resident, and resident representative, if applicable. It must include interventions that meet the resident's discharge goals, health and safety needs, and preferences. It must also take into consideration whether a caregiver or support person is available post-discharge to provide care the resident needs and has both the capacity and capability to do so.

In addition, discharge planning must identify the discharge destination,[91] and ensure a smooth and safe transition from the facility to the post-discharge setting.[92]

The Post-Discharge Plan Must Specify How the Resident Will Get the Care They Need

Federal Regulation: 42 CFR § 483.21(c)(2)(iv)

The post-discharge plan of care must be created with the resident and the resident representative, with resident consent.

It must indicate:

- where the individual plans to reside;
- any arrangements that have been made for the resident's follow-up care;
- any post-discharge medical and nonmedical services; and
- arrangements made for community care and support, if needed.

A Discharge Location That Is Unsafe or Does Not Meet Health or Safety Needs can Trigger an Immediate Jeopardy Investigation

CMS State Operations Manual Appendix Q – Core Guidelines for Determining Immediate Jeopardy

In subpart X of Appendix Q of the State Operations Manual, "*Discharge to a destination that is unsafe, or does not meet the resident's immediate health and/or safety needs*," is a situation that triggers further investigation. A report or complaint to the Utah Department of Health and Human Services about such a discharge would initiate an investigation by a survey team to determine if the discharging facility meets federal

[91] *State Operations Manual, Appendix PP, supra* note 11.
[92] Ctrs. for Medicare & Medicaid Servs., *State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities*, Intent, 42 CFR § 483.21(c)(1), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf (November 22, 2017).

regulatory requirements. If non-compliance is identified, the survey team investigates to determine if the non-compliance caused a potential for harm or actual harm to a resident(s). The survey team also investigates to determine if the non-compliance caused or had the potential to cause serious injury, impairment or death of a resident(s).

> **Immediate Jeopardy**
>
> A situation in which the facility's noncompliance with one or more federal regulations has caused or is likely to cause serious injury, harm, impairment, or death to a resident. It is the highest possible level of harm to a resident.
>
> (42 CFR § 488.301 CMS State Operations Manual Appendix Q – Core Guidelines for Determining Immediate Jeopardy. (Rev. 187, Issued: 03-06-19)

Placing a Resident in a Situation that Endangers Them is a Crime

Utah Criminal Code: Offenses Against the Person, Assault and Related Offenses, Abuse, Neglect, or Exploitation of a Vulnerable Adult 76-5-111(2) & (3)

Under Utah law, anyone, including a caretaker, who causes or permits a vulnerable adult to be placed in a situation where the adult's person or health is endangered is guilty of either aggravated abuse or abuse of a vulnerable adult.

2 SITUATION #2: Refusal to Permit Residents to Return from a Hospital Stay or Therapeutic Leave

In some situations, a facility will transfer a resident to the hospital or to a behavioral health unit and then refuse to take the resident back after the hospitalization (or after a therapeutic leave). Utah and federal regulations guarantee the resident can return to the facility except under a few very limited circumstances.

Facility Bed-Hold Policies, if Applicable, May Permit the Resident to Return to the Facility

Federal Regulation: 42 CFR § 483.15(d)(1)-(2)

A facility must have a policy about holding a resident's bed in case of hospitalization or therapeutic leave. Holding a bed means the bed is still the resident's and they have the right to return to it following hospitalization or therapeutic leave. The facility must explain if it will hold a bed for residents on Medicaid, Medicare, and private pay, respectively. The facility must also explain the duration and the cost of the bed-hold.

> The State of Utah does not pay for a facility to hold a bed for a resident on Medicaid, and Medicare does not pay to hold a bed for those receiving Medicare skilled nursing facility coverage. However, any resident can use their own funds to hold a bed.

Residents on Medicare or Medicaid Must Be Permitted to Return to the Facility if They Need Nursing Home Care

Federal Regulation: 42 CFR § 483.15(e)(1)(i)

Each facility must have a written policy that permits a resident whose bed-hold period is up to return to their room, or the next available semi-private room if the resident is eligible for payment by Medicaid or Medicare and if they need nursing facility care. Since neither the Utah Medicaid program nor Medicare pays to hold a bed, the bed-hold period for residents on Medicaid or Medicare is essentially "zero days." This means that after a hospitalization or therapeutic leave, no matter its duration, the bed-hold period is automatically considered to have been exceeded, and this regulation would apply.

A Facility Cannot Base Its Refusal to Permit a Resident to Return on the Resident's Condition at the Time of the Transfer to the Hospital / Behavioral Unit

Federal Guidance: 42 CFR § 483.15(e)(1)

A facility may have concerns about permitting a resident to return to the facility after a hospital stay due to the resident's clinical or behavioral condition at the time of transfer. The facility must not evaluate the resident based on their condition when originally transferred to the hospital.

The resident's medical record should show evidence that the facility made efforts to:

- determine if the resident still requires services and is eligible for Medicare or Medicaid;
- obtain an accurate status of the resident's condition;
- find out what treatments, medications, and services were provided by the hospital, and determine whether the facility can provide them; and
- work with the hospital to ensure the resident's needs and condition are within the nursing home's scope of care.

Example

A facility sends a resident who has been lashing out at others during meals to the hospital because staff believes is endangering others. While in the hospital, the resident receives treatment and shows no signs of striking out or endangering others. The doctor issues an order for discharge back to the nursing home. After hospitalization, the facility will not permit the resident to return because she had been a danger to others before. Because there is no evidence in hospital records that the resident continues to be a danger to self or others, the facility must permit the resident to come back.

The Transfer Becomes a Discharge if the Facility Does Not Permit the Resident to Return

Federal Regulation: 42 CFR § 483.15(e)(1)(ii)

If a facility does not allow a resident to return from a hospital after being transferred with the expectation of returning, the transfer becomes a discharge. To proceed with the discharge, the facility must have evidence that the decision is not based on the resident's condition at the time of transfer[93] and meets one of the six permissible reasons for discharge. The proposed discharge must follow all the transfer/discharge requirements at §483.15(c), including issuing a written 30-day notice of discharge, the right to appeal, and documentation, etc.

> If the facility claims it cannot meet the resident's needs, the resident's physician must document the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
>
> (42 CFR 483.15(c)(2)(i)(B))

Residents Who Appeal the Discharge While Outside the Facility Must Be Permitted to Return

State Operations Manual Appendix PP - Guidance to Surveyors for Long-Term Care Facilities 42 CFR § 483.15(c)(1)(ii)

If a resident in the hospital wishes to appeal a proposed discharge from the facility, the facility must allow the resident to return to his or her room or an available bed in the nursing home during the appeal process, with one exception.[94] If the facility has evidence that the resident's return would endanger the health or safety of the resident or other individuals in the facility, it may refuse to permit the resident to return pending the appeal.[95] However, a facility's determination to not permit a resident to return while an appeal of the resident's discharge is pending must not be based on the resident's condition when originally transferred to the hospital.[96]

[93] *State Operations Manual, Appendix PP, supra* note 11.
[94] Ctrs. for Medicare & Medicaid Servs., *State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities*, Guidance, 42 CFR § 483.15(e)(1), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf (November 22, 2017).
[95] *State Operations Manual, Appendix PP, supra* note 25.
[96] *State Operations Manual, Appendix PP, supra* note 11.

3 SITUATION #3: Discharge Due to Termination of Medicare Coverage

Residents Have the Right to Notice About the End of Medicare Coverage and the Right to Appeal to Have Medicare Services Continue

Federal Regulation: 42 CFR 405, Subpart I

Medicare pays for skilled services in a skilled nursing facility for a Medicare beneficiary who meets certain conditions. When the facility believes a resident will soon no longer qualify for Medicare skilled services, the facility must give the resident a written notice called the Notice of Medicare Non-Coverage (NOMNC). The notice informs the resident of the facility's decision to end Medicare services and the resident's right to an immediate appeal (i.e., Expedited Appeal) through Kepro. **The notice must be delivered at least two calendar days before Medicare covered services end.** If Kepro rules against the resident, there are several additional levels of appeal that can be pursued.

Kepro is the Beneficiary Family-Centered Care Quality Improvement Organization (BFCC-QIO) in Utah.

(https://www.keproqio.com/bene/statepages/utah)

Demand Bill

If requested by the resident, the facility must continue to bill Medicare for the services even though the provider does not think that Medicare will cover them.

The facility must also issue a Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) if it expects the resident will remain in the facility and continue to receive services after Medicare coverage ends. The SNFABN informs the beneficiary of potential liability for the non-covered stay so the resident can decide if they wish to continue receiving skilled services and assume financial responsibility. It also gives residents the option to request a demand bill. When a demand bill is requested, a third party entity decides whether Medicare will pay for the skilled services.

The Determination That Coverage Must End Cannot Be Based on the Resident Having Reached a Plateau

Medicare coverage for skilled services is sometimes erroneously stopped when the facility believes a resident is not making progress and has reached a plateau. Medicare regulations,[97] the CMS Medicare Benefit Policy Manual,[98] and a court ruling, Jimmo v. Sebelius,[99] clarify that the potential for recovery or improvement is **not** the deciding factor in whether an individual qualifies for skilled services. Rather, **the key issue is whether the skills of a professional nurse or qualified therapist are needed to prevent further deterioration or preserve current capabilities**.

[97] 42 CFR § 409.32(c); 42 CFR §409.33(c)(5)
[98] CMS Medicare Benefit Policy Manual 100-02, Chapter 8, §30.2.2. Principles for Determining Whether a Service is Skilled https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c08pdf.pdf
[99] Jimmo v. Sebelius Settlement Agreement. 10/16/2012. https://www.medicareadvocacy.org/wp-content/uploads/2012/12/Settlement-Agreement-for-Web.pdf

> Maintaining or slowing deterioration of an individual's condition is clearly defined as a skilled service.
>
> (Jimmo v. Sebelius Settlement Agreement)

The End of Medicare Coverage Does Not Trigger a Discharge from the Facility Unless the Resident No Longer Needs Nursing Home Care and/or Chooses to Leave

Federal Guidance: 42 CFR § 483.10(g)(17)-(18)

Although notices must be given for both the end of Medicare coverage and a facility-initiated discharge, they should not be confused as one and the same. A facility's requirement to notify and explain the Medicare notices that the individual is no longer receiving Medicare Part A services is **separate from and unrelated to** the admission and discharge requirements under 42 CFR § 483.15, which outline the notification and requirements under which an individual may be discharged from the facility.

> A resident can only be discharged for six permissible reasons. The end of Medicare coverage is not a valid reason for discharge.

Discharge Due to the End of Medicare Coverage and a Subsequent Change in Payment Source Are Not Permissible Reasons for Transfer/Discharge

Federal Regulation: 42 CFR § 483.15(c)(1)

Because the six permissible reasons for transfer/discharge do not include a change in a resident's payment status, residents cannot be discharged because Medicare will no longer be paying for their stay. When Medicare skilled care coverage ends, residents who still need nursing home level of care can remain in the facility and pay privately for their care or have their care paid for by Medicaid or another payment source. The facility should ensure the resident has the necessary assistance to submit the Medicaid paperwork (or any other third-party paperwork if other funding is sought).[100]

[100] State Operations Manual, Appendix PP, supra note 11.

4 SITUATION #4: Financial Exploitation

As noted in Section 1, an unpaid bill does not always mean the resident is being financially exploited. Regardless of the reason, when the facility is not being paid, it should ensure that prompt notice is given to whomever is responsible for paying the resident's bill. However, as discussed in Section 2 under "Freedom from abuse, neglect, and exploitation," there may be situations in which the individual controlling the resident's money financially exploits the resident and takes the money for their own personal use instead of using it to pay the resident's nursing home bill. As a result, the resident may end up owing the nursing home thousands of dollars. However, nursing home and other state and federal laws and regulations require the facility to take action to prevent this from happening and provide options other than discharge to address the situation.

The Facility Must Report Suspected Financial Exploitation

Federal Regulations: 42 CFR § 483.12(b)(5); 42 CFR § 483.12 (c)(1)
Utah Criminal Code: Offenses Against the Person, Assault and Related Offenses, Abuse, Neglect, or Exploitation of a Vulnerable Adult 76-5-111(2) & (3)

Financial exploitation is a crime. Therefore, a facility must report any suspected financial exploitation to:

Local Law Enforcement
Refer to your local law enforcement agency's non-emergency telephone number.

Adult Protective Services
Utah Department of Health and Human Services, Division of Aging and Adult Services,
Office of Adult Protective Services:
1-800-371-7897 (All counties except Salt Lake County.)
1-801-538-3567 (Salt Lake County)
https://leaps.dhhs.utah.gov/LeapsIntake

State Survey Agency
Utah Department of Health and Human Services,
Division of Licensing and Background Checks,
Office of Licensing:
1-800-662-4157 (All counties except Salt Lake County)
1-801-273-2994 (Salt Lake County)
https://health.utah.gov/hflcra/forms/Complaint/New_ComplaintFormStatic.pdf
https://health.utah.gov/hflcra/forms/Complaint/New_EntityReportStatic.pdf

All reports must be made immediately but no later than 24 hours after first suspecting the exploitation or after an allegation has been made known to the facility.

The facility should notify these entities before proceeding to discharge; action from these agencies may stop the financial exploitation that has led to nonpayment.

The Facility Can File with Social Security to Be Appointed the Resident's Representative Payee

Federal Law: 42 USC § 405(j)(1)(A)

If a resident is not capable of handling their own Social Security benefits and/or the resident's representative is misusing the resident's benefits, and another appropriate representative payee is not forthcoming, a facility can apply to be the representative payee for the resident. If appointed, the facility would directly receive the resident's Social Security check. This approach may resolve the problem of future nonpayment.

> The Social Security Administration has a program in which a representative payee can be appointed to receive the Social Security or SSI benefits for anyone who cannot manage or direct the management of their benefits.
>
> (https://www.ssa.gov/payee)

SECTION 4:

Fair Hearing Process for Resident Appeals of Transfers/Discharges

Residents have the right to appeal a transfer or discharge initiated by a facility. This section provides a general overview of the appeal process in Utah based on federal nursing home regulations (42 CFR § 483.15) and Utah Administrative Code governing Administrative Hearing Procedures (R410-14).

Notice of Appeal Rights

42 USC § 1396r(e)(3); 42 CFR § 483.15 (c)(5)(iv)

Any resident who has received a notice of transfer/discharge from the facility has the right to appeal the proposed transfer/discharge.

The notice must include:

- a statement of the resident's appeal rights;
- the name, address (mailing and email), and telephone number of the entity which conducts the appeal hearings; and
- information on how to obtain an appeal form, and assistance in completing the form and submitting the appeal hearing request.

Requesting a Hearing

R410-14-5(1)-(2)

To request a hearing, the resident or someone representing the resident must complete the "Form to Request a State Fair Hearing" and mail or fax it to:

Utah Department of Health and Human Services
Office of Administrative Hearings
Box 143105
Salt Lake City, UT 84114-3105
FAX: **801-536-0143**
PHONE: **801-538-6576**

Recommended action:
Call the Director's Office/ Hearings Unit to confirm the hearing request has been received.
PHONE: **801-538-6576**

The form can be obtained by going to **https://medicaid.utah.gov/utah-medicaid-forms** and then clicking on **HearingRequest2020.pdf**.

The resident must request a hearing within 30 calendar days from the date they receive the notice.

See **APPENDIX 5: Completing the "Form to Request a State Fair Hearing:" Directions for Residents When Appealing a Notice of Transfer or Discharge** for information on how to complete the form.

Remaining in Facility While Appeal is Pending

42 CFR § 483.15 (c)(1)(ii)

When a resident files a request for hearing, the facility may not transfer or discharge the resident while the appeal is pending unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to discharge or transfer would pose.

Notice of Hearing

R410-14-7

Upon receipt of a hearing request, a representative with the Hearing's Office will notify the resident and anyone who is representing the resident of the date, time, and place of the hearing at least 10 calendar days before the date of the hearing, unless all parties agree to a different time frame.

Prehearing

R410-14-8

The Office of Administrative Hearings must schedule a prehearing conference within 30 calendar days from the date it receives the request for a hearing. The prehearing conference may be held by phone.

The purpose of the prehearing conference is to determine if a hearing needs to be held. At this time, the hearing officer and both parties discuss the factual and legal issues in the case, review potential evidence, and arrange for any exchange of documents and information if needed.

Conducting the Hearing

R410-14-10

The hearing is conducted by an impartial Administrative Hearing Officer (AHO). The AHO will decide where the hearing will be held. Generally, hearings are held at the Administrative Hearing's "Hearing Room," with parties attending inperson or via telephone.

The rights of each party include the right to:

- present evidence, and rebut the evidence against them;
- bring witnesses and cross examine the other party's witnesses; and
- introduce exhibits.

Decision

R410-14-14

The Office of Administrative Hearings will send a written copy of the decision to each party or representative.

Agency Review

R410-14-16; 63G-4-301(1)(a)

Either party can appeal the decision (called reconsideration) to the Utah Department of Health and Human Services. The written request for review must be filed within 30 days of the date the decision was issued.

Conclusion

It is critical that providers, ombudsmen, legal services, and other stakeholders fully comprehend the state and federal rules and guidance around transfers and discharges. This manual is intended to serve as the “go-to” place for that information and to promote greater understanding of transfer/discharge requirements. Equipped with this knowledge, all stakeholders should be better positioned to prevent inappropriate transfers/discharges and effectively protect and support nursing home residents faced with transfer or discharge.

APPENDIX 1:

Utah and Federal Regulations Pertaining to Facility-Initiated Transfers or Discharges in Nursing Homes: A Side-by-Side Comparison

	Federal Regulation		Utah Regulation		
Topic	Citation	Language	Citation	Language	**Key Difference**
Permitting residents to stay in the facility and written policies	42 CFR § 483.15(c)(1)(i)	(1) Facility requirements - (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless -	R432-150-22(1)	(1) Each facility must develop written admission, transfer and discharge policies and make these policies available to the public upon request. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless:	Utah regulation requires each facility to have written transfer and discharge policies; such policies must be made available to the public upon request.
Reason for transfer or discharge: resident's needs	42 CFR § 483.15(c)(1)(i)(A)	(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;	R432-150-22(1)(a)	(a) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;	N/A
Reason for transfer or discharge: improvement of health	42 CFR § 483.15(c)(1)(i)(B)	(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;	R432-150-22(1)(b)	(b) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;	N/A
Reason for transfer or discharge: safety endangered	42 CFR § 483.15(c)(1)(i)(C)	(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;	R432-150-22(1)(c)	(c) The safety of individuals in the facility is endangered;	Under federal regulation, transfer/discharge is only permitted if endangerment results from the clinical or behavioral status of the resident.

	Federal Regulation		Utah Regulation		
Topic	Citation	Language	Citation	Language	**Key Difference**
Reason for transfer or discharge: health endangered	42 CFR § 483.15(c)(1)(i)(D)	(D) The health of individuals in the facility would otherwise be endangered;	R432-150-22(1)(d)	(d) The health of individuals in the facility is endangered;	N/A
Reason for transfer or discharge: nonpayment	42 CFR § 483.15(c)(1)(i)(E)	(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Non-payment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or	R432-150-22(1)(e)	(e) The resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility; or	Federal regulation specifies when non-payment applies, particularly regarding third party payments by Medicare or Medicaid.
Reason for transfer or discharge: facility closure	42 CFR § 483.15(c)(1)(i)(F)	(F) The facility ceases to operate.	R432-150-22(1)(f)	(f) The facility ceases to operate.	N/A
Pending appeal	42 CFR § 483.15(c)(1)(ii)	(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.	N/A	N/A	Federal regulation prohibits the facility from transferring or discharging a resident during an appeal, except under very limited circumstances.

	Federal Regulation		Utah Regulation		
Topic	Citation	Language	Citation	Language	**Key Difference**
Documentation	42 CFR § 483.15(c)(2)	(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.	R432-150-22(2)	(2) The facility must document resident transfers or discharges under any of the circumstances specified in R432-150-22(1)(a) through (f), in the resident's medical record. The transfer or discharge documentation must be made by:	Federal regulation adds that appropriate information must be given to the receiving health care institution or provider.
Documentation	42 CFR § 483.15(c)(2)(i)	(i) Documentation in the resident's medical record must include: (A) the basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).	N/A	N/A	Federal regulation requires the basis for any transfer or discharge to be documented in the resident's medical record. Additional information must be documented if the reason is that the resident's needs cannot be met.
Documentation	42 CFR § 483.15(c)(2)(ii)(A)	(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by - (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and	R432-150-22(2)(a)	(a) the resident's physician if transfer or discharge is necessary under R432-150-22(1)(a) and (b);	N/A
Documentation	42 CFR § 483.15(c)(2)(ii)(B)	(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.	R432-150-22(2)(b)	(b) a physician if transfer or discharge is necessary under R432-150-22(1)(c) and(d).	N/A

	Federal Regulation		Utah Regulation		
Topic	Citation	Language	Citation	Language	**Key Difference**
Information to receiving provider	42 CFR § 483.15(c)(2)(iii)	(iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident (B) Resident representative information including contact information. (C) Advance Directive information. (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals, (F) All other necessary information, including a copy of the resident's discharge summary, consistent with § 483.21(c)(2), as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.	N/A	N/A	Federal regulation specifies what information must be sent to the receiving provider.
Notice before transfer or discharge	42 CFR § 483.15(c)(3)	(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must -	R432-150-22(3)	(3) Prior to the transfer or discharge of a resident, the facility must:	N/A
Notice before transfer or discharge	42 CFR § 483.15(c)(3)(i)	(i) 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.	R432-150-22(3)(a)	(a) provide written notification of the transfer or discharge and the reasons for the transfer or discharge to the resident, in a language and manner the resident understands, and, if known, to a family member or legal representative of the resident;	Federal regulation requires a representative from the Office of the State Long-Term Care Ombudsman be notified; Utah regulation includes notification of a family member or legal representative "if known."

	Federal Regulation		Utah Regulation		
Topic	Citation	Language	Citation	Language	**Key Difference**
Notice before transfer or discharge	42 CFR § 483.15(c)(3)(ii)	(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and	R432-150-22(3)(b)	(b) record the reasons in the resident's clinical record; and	N/A
Notice before transfer or discharge	42 CFR § 483.15(c)(3)(iii)	(iii) Include in the notice the items described in paragraph (c)(5) of this section.	R432-150-22(3)(c)	(c) include in the notice the items described in R432-150-22(6).	N/A
Timing of notice	42 CFR § 483.15(c)(4)(i)	(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.	R432-150-22(4)	(4) Except when specified in R432-150-22(5)(a), the notice of transfer or discharge required under R432-150-22(3), must be made by the facility at least 30 days before the resident is transferred or discharged.	N/A
Timing of notice	42 CFR § 483.15(c)(4)(ii)	(ii) Notice must be made as soon as practicable before transfer or discharge when -	R432-150-22(5)	(5) Notice may be made as soon as practicable before transfer or discharge if:	Federal regulation says notice "must" be made and Utah regulation says notice "may" be made as soon as practicable.
Timing of notice	42 CFR § 483.15(c)(4)(ii)(A) and (B)	(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(ii)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(ii)(D) of this section;	R432-150-22(5)(a)	(a) the safety or health of individuals in the facility would be endangered if the resident is not transferred or discharged sooner;	Federal regulation distinguishes health and safety by listing them in two different sections.
Timing of notice	42 CFR § 483.15(c)(4)(ii)(C)	(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;	R432-150-22(5)(b)	(b) the resident's health improves sufficiently to allow a more immediate transfer or discharge;	N/A

	Federal Regulation		Utah Regulation		
Topic	Citation	Language	Citation	Language	**Key Difference**
Timing of notice	42 CFR § 483.15(c)(4)(ii)(D)	(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or	R432-150-22(5)(c)	(c) an immediate transfer or discharge is required by the resident's urgent medical needs; or	N/A
Timing of notice	42 CFR § 483.15(c)(4)(ii)(E)	(E) A resident has not resided in the facility for 30 days.	R432-150-22(5)(d)	(d) a resident has not resided in the facility for 30 days.	N/A
Contents of the notice	42 CFR § 483.15(c)(5)	(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:	R432-150-22(6)	(6) The contents of the written transfer or discharge notice must include the following:	N/A
Contents of the notice	42 CFR § 483.15(c)(5)(i)	(i) The reason for transfer or discharge;	R432-150-22(6)(a)	(a) the reason for transfer or discharge;	N/A
Contents of the notice	42 CFR § 483.15(c)(5)(ii)	(ii) The effective date of transfer or discharge;	R432-150-22(6)(b)	(b) the effective date of transfer or discharge;	N/A
Contents of the notice	42 CFR § 483.15(c)(5)(iii)	(iii) The location to which the resident is transferred or discharged;	R432-150-22(6)(c)	(c) the location to which the resident is transferred or discharged; and	N/A
Contents of the notice	42 CFR § 483.15(c)(5)(iv)	(iv) 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;	N/A	N/A	Federal regulation requires notice of appeal rights.

	Federal Regulation		Utah Regulation		
Topic	Citation	Language	Citation	Language	**Key Difference**
Contents of the notice	42 CFR § 483.15(c)(5)(v)	(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;	R432-150-22(6)(d)	(d) the name, address, and telephone number of the State and local Long Term Care Ombudsman programs.	Federal regulation requires email address; Utah regulation requires name of the State Office and local LTCOPs.
Contents of the notice	42 CFR § 483.15(c)(5)(vi)	(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 USC 15001 et seq.); and	R432-150-22(6)(e)	(e) For nursing facility residents with developmental disabilities, the notice must contain 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.	Federal regulation broadens the requirement to include residents with intellectual disabilities as well as residents with related disabilities. Federal regulation also requires including in the notice the email address of the agency responsible for protection and advocacy.
Contents of the notice	42 CFR § 483.15(c)(5)(vii)	(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.	R432-150-22(6)(f)	(f) For nursing facility residents who are mentally ill, the notice must contain the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.	Federal regulation uses the term “residents with a mental disorder” and broadens the requirement to include “related disorders.” Federal regulation requires an email address of the agency responsible for protection and advocacy.

	Federal Regulation		Utah Regulation		
Topic	Citation	Language	Citation	Language	**Key Difference**
Changes to the notice	42 CFR § 483.15(c)(6)	(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.	N/A	N/A	Federal regulation mandates that recipients of the notice be updated of changes.
Notice of bed-hold policy before transfer	42 CFR § 483.15(d)	(d) Notice of bed-hold policy and return –	R432-150-22(8)	(8) Notice of resident bed-hold policy, transfer and re-admission must be documented in the resident file.	Utah regulation requires documentation in the resident file of bed-hold policy, transfer and re-admission.
Notice of bed-hold policy before transfer	42 CFR § 483.15(d)(1)	(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies -	R432-150-22(8)(a)	(a) Before a facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the facility must provide written notification and information to the resident and a family member or legal representative that specifies:	Federal regulation requires notice to "resident or resident representative." Utah regulation requires notice to "resident and a family member or legal representative."
Notice of bed-hold policy before transfer	42 CFR § 483.15(d)(1)(i)	(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;	N/A	N/A	Federal regulation requires information about the state bed-hold policy under Medicaid.
Notice of bed-hold policy before transfer	42 CFR § 483.15(d)(1)(ii)	(ii) The reserve payment policy in the state plan, under § 447.40 of this chapter, if any	N/A	N/A	Federal regulation requires information about the reserve payment plan under the state plan.

	Federal Regulation		Utah Regulation		
Topic	Citation	Language	Citation	Language	**Key Difference**
Notice of bed-hold policy before transfer	42 CFR § 483.15(d)(1)(iii)	(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and	R432-150-22(8)(a)	(i) the facility's policies regarding bed-hold periods permitting a resident to return; (ii) the duration of the bed-hold policy, if any, during which the resident is permitted to return and resume residence in the facility.	Federal regulation requires policies to be consistent with paragraph 42 CFR § 483.15(e)(1).
Notice of bed-hold policy before transfer	42 CFR § 483.15(d)(1)(iv)	(iv) The information specified in paragraph (e)(1) of this section.	N/A	N/A	Federal regulation states facility bed-hold policy must permit residents to return to their previous room or first available bed in a semi-private room under certain circumstances; also sets facility requirements when a transfer becomes a discharge
Bed-hold notice upon transfer	42 CFR § 483.15(d)(2)	(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.	R432-150-22(8)(b)	(b) At the time of transfer of a resident to a hospital or for therapeutic leave, the facility must provide written notice to the resident and a family member or legal representative, which specifies the duration of the bed-hold policy.	Federal regulation specifies bed-hold notice must go to the "resident representative;" Utah regulation uses "family member or legal representative."

	Federal Regulation		Utah Regulation		
Topic	Citation	Language	Citation	Language	**Key Difference**
Notice during medical emergencies	N/A	N/A	R432-150-22(8)(c)	(c) If transfers necessitated by medical emergencies preclude notification at the time of transfer, notification shall take place as soon as possible after transfer.	Utah regulation establishes requirements for notice in medical emergencies.
Permitting residents to return to the facility	42 CFR § 483.15(e)(1)(i)-(ii)	(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident (A) Requires the services provided by the facility; and (B) is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges.	R432-150-22(8)(d)	(d) The facility must establish and follow a written policy under which a resident whose hospitalization or therapeutic leave exceeds the bed-hold period is readmitted to the facility.	Federal regulation specifies that the policy must permit residents to return to their previous room or first available bed in a semi-private room under certain circumstances; also sets facility requirements when a transfer becomes a discharge.

APPENDIX 2:

Facility-Initiated Transfers or Discharges Required Information for Receiving Provider

This checklist is designed to help ensure nursing homes give the receiving provider all information required under federal and state regulations.[101]

Facilities may choose their own method of communicating transfer or discharge information, such as through a universal transfer form or an electronic health record summary. The information transmitted electronically must be secure, protect the resident's privacy, and meet the receiving facility's capacity for review and use of the information.[102]

Transfer or Discharge

All information must be conveyed as close as possible to the actual time of transfer or discharge.

General information

- ☐ Contact information of the practitioner who was responsible for the care of the resident
- ☐ Resident representative information, including contact information
- ☐ Advance directive information

Special instructions and/or precautions for ongoing care, as appropriate, which must include, if applicable, but are not limited to:[103]

- ☐ Treatments and devices (oxygen, implants, IVs, tubes/catheters)
- ☐ Precautions (isolation or contact)
- ☐ Special risks (falls, elopement, bleeding, pressure injury and/or aspiration precautions)
- ☐ Resident's comprehensive care plan goals

[101] 42 CFR § 483.15(c)(2)(iii), R432-150-13 (5)
[102] Ctrs. for Medicare & Medicaid Servs., *State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities*, Guidance, § 483.15(c)(2)(iii), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf (November 22, 2017).
[103] Id.

All information necessary to meet the resident's needs, which includes, but may not be limited to:[104]

- ☐ Resident status, including baseline and current mental, behavioral, and functional status, reason for transfer, recent vital signs
- ☐ Diagnoses and allergies
- ☐ Medications (including when last received)
- ☐ Most recent relevant labs, other diagnostic tests, and recent immunizations
- ☐ Additional information, if any, outlined in the transfer agreement with the acute care provider (see 42 CFR § 483.70(j))

Discharge Only

In addition to the information listed above, in cases of discharge, the facility must prepare and transmit to the receiving provider a **discharge summary**.[105] The facility must furnish the discharge summary to the receiving provider at the time the resident leaves the facility.[106]

The discharge summary includes:

1. **A concise summary of resident's stay and course of treatment**, including, but not limited to:
   - ☐ Diagnoses
   - ☐ Course of illness
   - ☐ Treatment or therapy
   - ☐ Pertinent lab, radiology, and consultation results[107]

[104] Id.
[105] 42 CFR §483.21(c)(2)
[106] Ctrs. for Medicare & Medicaid Servs., *State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities*, Guidance, §483.21(c)(2), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf (November 22, 2017).
[107] Id.

2 **A final summary of the resident's status**, including the resident's most recent comprehensive assessment (see § 483.20(b)(1)) that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. This includes:

- ☐ Identification and demographic information
- ☐ Customary routine
- ☐ Cognitive patterns
- ☐ Communication
- ☐ Vision
- ☐ Mood or behavior patterns
- ☐ Psychosocial well-being
- ☐ Physical functioning and structural problems
- ☐ Continence
- ☐ Disease diagnoses and health conditions
- ☐ Dental and nutritional status
- ☐ Skin condition
- ☐ Activity pursuit
- ☐ Medications
- ☐ Special treatments and procedures
- ☐ Discharge planning (most recent discharge care plan)
- ☐ Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the MDS
- ☐ Documentation of participation in assessment (i.e., documentation that refers to who participated in the assessment process, which must include direct observation and communication with the resident and communication with licensed and non-licensed direct care staff members on all shifts)[108]

[108] Id.

3 **Medication information**

- ☐ Medication reconciliation that compares pre-discharge medications to post-discharge medications by creating an accurate list of both prescription and over the counter medications that includes the drug name, dosage, frequency, route, and indication for use for the purpose of preventing unintended changes or omissions at transition points in care.[109]

4 **A post-discharge plan of care** developed with the participation of the resident and, with the resident's consent, the resident representative(s). The post-discharge plan of care must indicate:

- ☐ Where the resident will live after leaving the facility
- ☐ Follow-up care the resident will receive from other providers, and that provider's contact information
- ☐ Needed medical and non-medical services (including medical equipment)
- ☐ Community care and support services, if needed
- ☐ When and how to contact the continuing care provider[110]

[109] *Ctrs. for Medicare & Medicaid Servs., State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities*, Definition, §483.21(c)(2), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf (November 22, 2017).
[110] *Ctrs. for Medicare & Medicaid Servs., State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities*, Guidance, §483.21(c)(2), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf (November 22, 2017).

APPENDIX 3

STATE of UTAH
LONG-TERM CARE
OMBUDSMAN

"Discharge Notification Facility Guidance"

by the State of Utah Long-Term Care Ombudsman Program

Federal regulations now require facilities to send a copy of the transfer or discharge notice, provided to the resident and the resident's representative, to a representative of the Office of the State Long-Term Care Ombudsman. This correspondence provides guidance when notice to the Office of the State of Utah Long-Term Care Ombudsman is required.

What type of facilities have to follow this CMS rule?

- In accordance with Title 42 of the Code of Federal Regulations (CFR) 483, this rule applies to Skilled Nursing Facilities (SNF), Nursing Facilities (NF), and dually participating Skilled Nursing Facilities/Nursing Facilities (SNF/NF). This rule does not include Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) or Assisted Living Facilities.

§483.5 Definitions.

(a) Facility defined. For purposes of this subpart, facility means a skilled nursing facility (SNF) that meets the requirements of sections 1819(a), (b), (c), and (d) of the Act, or a nursing facility (NF) that meets the requirements of sections 1919(a), (b), (c), and (d) of the Act. ''Facility'' may include a distinct part of an institution (as defined in paragraph (b) of this section and specified in § 440.40 and § 440.155 of this chapter), **but does not include an institution for the mentally retarded or persons with related conditions described in § 440.150 of this chapter**.

Can a resident be discharged while an appeal is pending?

- The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 , when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) , unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

What types of discharges and transfers should I notify the Ombudsman about?

- Facilities must notify the Office of the State of Utah Long-Term Care Ombudsman, any time a facility initiates a transfer or discharge of a resident for any of the following reasons:

  a) The resident's welfare and the resident's needs cannot be met in the facility;

  b) The resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

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

  d) The health of individuals in the facility would otherwise be endangered;

  e) The resident has failed, after reasonable and appropriate notice, to pay for (or have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or

  f) The facility ceases to operate.

- Facilities **are required** to send notices for emergency transfers.
- A **facility-initiated transfer or discharge** is a transfer or discharge which the resident objects to, did not originate through a resident's verbal or written request, and/or is not in alignment with the resident's stated goals for care and preferences.

What types of transfers and discharges don't have to be reported to the Ombudsman Program?

- Facilities are **not required** to send copies of notices for resident self-initiated transfers or discharges.

What is considered a self-initiated discharge?

- A resident is determined to have **initiated** the discharge when 1) it is consistent with previously-identified goals of care and preferences as outlined in the care plan, or 2) the resident, representative or family has provided written notice to the facility that they intend to leave the facility.

When should I notify the Ombudsman?

- Facilities must give the resident and their representative a notice of discharge or transfer at least **30 days** in advance unless one of the exceptions outlined in 42 CFR 483.15(c)(4)(ii) applies. The facility **must send copies** of these notices to the Office of the State of Utah Long-Term Care Ombudsman at the **same time**.
- When a resident is **temporarily transferred** on an emergency basis to an acute care facility, notice of transfer may be provided to the resident and resident representative as soon as practicable (42 CFR 483.15 (c)(4)(ii)(D)). Copies of these notices can also be sent to the ombudsman when practicable, such as in a **monthly list**.
- If the facility decides to **discharge** a resident for one of the allowed reasons while the resident is still hospitalized, the facility must send a 30-day notice of discharge to the resident and resident representative. In this case, the facility must also send a copy of the notice to the ombudsman at the **same time** it provides notice to the resident or the resident's representative.

What should be included on each notice?

- The notice should include the resident's name and the facility's name, address, and the contact information, as well as all information required under 42 CFR 483.15(c)(5).

Which Ombudsman should I notify?

- New regulations refer to the "Representative of the Office of the State Long-Term Care Ombudsman." For purposes of this notice, please send all discharge notices to the State of Utah Long-Term Care Ombudsman.

How should I notify the Ombudsman?

- Send a copy of the same notice you provided the resident and resident representative. Send by email (scanned copy of discharge/transfer notice), or fax.

  EMAIL: **sltcop@utah.gov**
  FAX: **801-532-2217**

It is also suggested that you consult your legal counsel or industry trade association for additional guidance regarding discharge and transfer notices.

> For questions about this communication, you may contact:
>
> **Alianne Sipes**
> State of Utah Long-Term Care Ombudsman
> EMAIL: asipes@utah.gov
> ADDRESS: 195 N. 1950 W. SLC, UT 84116
> OFFICE: **801-538-3910** or **877-424-4640**

APPENDIX 4:

Sample Notice of Transfer or Discharge

For transfers or discharges initiated by the facility

To be completed by the facility

You must receive notice in writing if the nursing home wants to transfer or discharge you. The nursing home must give you this notice if you did not ask verbally or in writing to be transferred or discharged, the transfer or discharge is not consistent with the goals you shared for your care or your preferences, or if you do not agree with the transfer or discharge.

Type of Notice (Select one)

- ☐ This notice is a "facility-initiated" **transfer**, meaning you are expected to return to the facility.
- ☐ This notice is a "facility-initiated" **discharge**, meaning you are being discharged to another location and are not expected to return to the facility.

Effective Date of the Transfer or Discharge:

Transfer/Discharge Location

On the date of the transfer or discharge, you will be transferred or discharged to:

☐ Another nursing home ☐ An assisted living facility ☐ Your home ☐ Other

If "other" is chosen, please indicate the specific location here.

Receiving Facility/Person:

Address:

Phone Number:

Reason for Discharge

(Facilities must select at least one reason below and provide an explanation.)

- ☐ Your welfare and your needs cannot be met in the facility, as documented in your clinical record by your physician.
- ☐ Your health has improved sufficiently so you no longer need the services provided by this facility, as documented by your physician in your clinical record.
- ☐ The safety of individuals in this facility is endangered, as documented by a physician in your clinical record.

- ☐ The health of individuals in the facility would otherwise be endangered, as documented by a physician in your clinical record.
- ☐ You have failed, after reasonable and appropriate notice, to pay for your stay at this facility.
- ☐ This facility is ceasing to operate.

Facility's explanation:

Preparation and Orientation for Transfer or Discharge

Steps taken by the facility to provide you with sufficient preparation and orientation to ensure your safe and orderly transfer or discharge from this facility.

RESIDENT AND RESIDENT REPRESENTATIVE INFORMATION

Resident Name:

Room Number:

Phone Number:

Email Address:

Resident Representative:

Address:

Phone Number:

Email Address:

Date this Notice is given to the resident:

Date this Notice is given to the resident representative:

Date this Notice is given to the State Ombudsman:

TRANSFERRING/DISCHARGING FACILITY INFORMATION

Facility Name:

Address:

Phone Number:

Facility Contact Person and Title:

Contact Phone Number:

Contact Email Address:

Appeal Rights

If you think you should not have to leave the facility or if you think you should be able to return to the facility, you can appeal. You have **30 days** after receiving this notice to appeal the facility's decision to transfer or discharge you. To file an appeal, you must complete a state form, called the "Form to Request a State Fair Hearing." The form is available at **https://medicaid.utah.gov/utah-medicaid-forms**. It is called, "HearingRequest2020.pdf" or "HearingRequestSpanish2019.pdf" on the website. Send the completed form by mail, email or fax.

MAIL: Office of Administrative Hearings
Box 143105
Salt Lake City, UT 84114-3105

EMAIL: **administrativehearings@utah.gov**

FAX: **801-536-0143**

PHONE: **801-538-6576**

The facility may not transfer or discharge you while the appeal is pending unless the failure to discharge or transfer you would endanger the health or safety of individuals in the facility.

An ombudsman can provide you with information on how to obtain a "Form to Request a State Fair Hearing," and assist you with completing and submitting the form.

Assistance Available to You

The Office of the State Long-Term Care Ombudsman Program resolves problems and advocates for residents who live in nursing homes. Contact the Utah Long-Term Care Ombudsman Program to discuss your rights and options.

Office of the State Long-Term Care Ombudsman
195 North 1950 West
Salt Lake City, Utah 84116
801-538-3910 or **877-424-4640**
sltcop@utah.gov

Local Long-Term Care Ombudsman Program

The Disability Law Center can provide advice or representation for residents living with intellectual and/or developmental disabilities, mental disorders, or related disabilities.

Disability Law Center
205 North 400 West
Salt Lake City, UT 84103
800-662-9080
https://disabilitylawcenter.org

Applicable state and federal regulations: **R432-150-22 of the Utah Administrative Code** and **section 483.15 of Title 42 of the Code of Federal Regulations.**

APPENDIX 5:

Completing the "Form to Request a State Fair Hearing:" Directions for Residents When Appealing a Notice of Transfer or Discharge

2022

The "Form to Request a State Fair Hearing" is the form you need to use to appeal (i.e., ask for a hearing) a nursing home transfer or discharge. Because the form is designed for appeals related to Medicaid eligibility and services, not nursing home transfers and discharges, it can be confusing. This guide will explain the form and help you fill it out.

- At the top of the form where it says, "Are you asking for a fair hearing because of a decision made by the Medicaid agency or by a managed care plan," cross this out and write in "Nursing Home Transfer or Discharge Appeal." You could also put Transfer/Discharge Appeal in the box that's designated for "Name of Plan."
- Instead of enclosing a copy of the Medicaid Agency's denial notice or the Managed Care Plan's notice, include a copy of the written notice of discharge you received from the nursing home.
- Question #1: The person requesting the hearing may be the resident or someone helping the resident.
- Question #2: The "member" is the resident.
- Question #3: The "provider" is the name of the nursing home.
- Question #4: Put "Nursing home transfer or discharge appeal hearing."
- Question #5: Leave blank.
- Representation of the resident: State who, if anyone, will be representing the resident at the hearing. This could be anyone, including an attorney, long-term care ombudsman or other individual.
- The resident can have whomever they wish notified of the hearing request.