

LONG TERM CARE COMMUNITY COALITION

Advancing Quality, Dignity & Justice

LTCCC Memo: Addressing the Growing Problem of Inappropriate and Harmful Nursing Home Discharges in New York

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Summary of the Problem

Inappropriate transfer and discharge from nursing homes is recognized by the US Centers for Medicare & Medicaid Services (CMS) as a serious problem. In New York State, nursing home residents are experiencing what appears to be a growing wave of inappropriate, harmful and potentially unlawful discharges. In some areas of the state (particularly the NYC Metropolitan Area, which accounts for close to half of the nursing home residents in NY), residents are being discharged to homeless shelters, including homeless shelters that are not able to provide necessary services or accommodations. In other cases, residents are being discharged inappropriately to other facilities or so-called Home & Community Based Settings without the appropriate and necessary steps being taken to ensure that mandatory minimum transfer protocols are followed or that the transfer is safe and appropriate for the individual (as the law requires).

In addition to the recognition this problem has received from CMS, anecdotal reports from New Yorkers across the state (including families, advocates and LTC ombudsman) indicate that serious, often irreparable harm is being inflicted on some of the most vulnerable people in our state. These reports include:

- Residents receiving discharge notices that do not provide the necessary information as required by the state;
- Residents transferred from one facility to another owned by the same operator but in a less expensive or sought after region of the state;
- Residents discharged without any meaningful discharge planning (as required under state and federal law);
- Failure to provide meaningful 30 days' notice prior to discharge;

- Residents discharged before they or their family can make a suitable arrangement for community care; and
- Residents discharged to homeless shelters that are not ADA compliant.

Federal Actions to Protect Residents

As noted above, the federal Centers for Medicare & Medicaid Services (CMS) has recognized that this is a significant and growing problem across the country. Over the last two years, CMS has developed and implemented policies and procedures to address this problem, including strengthening protections against inappropriate discharges and requiring that discharge notices be sent to the LTC Ombudsman Programs.

What Can New York Do?

Following are recommendations for legislative/administrative actions:

1. **Planning Conferences.** Require nursing homes to hold a planning conference 14 days prior to a transfer or discharge. We recommend that the law be structured along the lines of that which exists in Wisconsin (see [Wisconsin Administrative Code, Health & Family Services, Section 132.53\(3\)](#)).
2. **Discharge Notices.** Standardize nursing home discharge notices. This is already required of NYS adult home facilities. Notices should include contact information (including email, website and phone) for the LTC Ombudsman Program, ICAN, Aging and Disability Resource Center, Adult Protective Services and the NYS Department of Health.
3. **Discharge Appeals.** Establish mechanisms for resident representation in discharge appeals. Currently, the vast majority of NYS nursing home residents have no representation or access to representation when appealing a discharge.
4. **Monitor Discharge Notices.** The new federal Requirements for nursing homes provide for discharge notices to go to a state's Long Term Care Ombudsman Program (LTCOP). In NYS, the LTCOP has implemented this policy by having facilities send discharge notices to the local LTCOPs. In addition to the lack of capacity of the local LTCOPs to effectively monitor, evaluate, and respond to potentially inappropriate discharges, this policy does not allow for state-wide monitoring and assessment of how nursing homes, especially chain-owned facilities, are abiding by the federal and state requirements that are in place to ensure that discharges are safe. Resources should be allocated to the state LTCOP office to collect and track discharge notices and publish an annual report on its findings.
5. **Stakeholder Education.** We recommend that NYDOH award a grant of CMP funds for education of residents, families, ombudsmen and advocates on discharge rights, including the new federal protections. CMP funds are a segregated account which, upon approval from CMS, can be used for projects and activities that improve care and quality of life for nursing home residents. Thus, this is a funding stream that would have no cost to the state. CMS has explicitly indicated that these funds can be used to support and train resident and family councils. Importantly, the

funds cannot be used for services that nursing homes are already paid to provide (thus, it would not be appropriate to give these funds to nursing homes to help them comply with the federal and state discharge planning and related requirements).

6. **“SWAT” Team.** NYDOH should establish a team (or designate staff) and furnish it with the tactical skills and resources to function, essentially, as a SWAT team to ensure that complaints about involuntary discharges are addressed in an effective and timely manner and to monitor for systemic problems. Now that NY has moved to mandatory managed LTC, this would be a valuable way for DOH to reallocate personnel and resources that were previously dedicated to other tasks, such as handling rate appeals. The reallocation of these agency resources to improve resident protections was proposed by DOH when plans to move to managed care (and provide the industry a “Universal Settlement”) were first announced.

Appendix I: NYS Nursing Home Transfer/Discharge Requirements

<https://regs.health.ny.gov/content/section-4153-residents-rights>

Excerpt:

With regard to the assurance of equal access to quality care, the facility shall establish and maintain identical policies and practices regarding transfer, discharge and the provision of all required services for all individuals regardless of source of payment.

Full Text on Transfer/Discharge:

(h) Transfer and discharge rights. Transfer and discharge shall include movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge shall not refer to movement of a resident to a bed within the same certified facility, and does not include transfer or discharge made in compliance with a request by the resident, the resident’s legal representative or health care agent, as evidenced by a signed and dated written statement, or those that occur due to incarceration of the resident.

(1) With regard to the transfer or discharge of residents, the facility shall:

(i) permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless such transfer or discharge is made in recognition of the resident's rights to receive considerate and respectful care, to receive necessary care and services, and to participate in the development of the comprehensive care plan and in recognition of the rights of other residents in the facility.

(a) The resident may be transferred only when the interdisciplinary care team, in consultation with the resident or the resident's designated representative, determines that:

(1) the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met after reasonable attempts at accommodation 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; or

(4) The health of individuals in the facility is endangered;

(b) Transfer and discharge shall also be permissible when the resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare, Medicaid or third party insurance) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid. Such transfer or discharge shall be permissible only if a charge is not in dispute, no appeal of a denial of benefits is pending, or funds for payment are actually available and the resident refuses to cooperate with the facility in obtaining the funds.

(c) Transfer or discharge shall also be permissible when the facility discontinues operation and has received approval of its plan of closure in accordance with subdivision (i) of Section 401.3 of this Subchapter.

(ii) ensure complete documentation in the resident's clinical record when the facility transfers or discharges a resident under any of the circumstances specified in subparagraph (i) of this paragraph. The documentation shall be made by:

(a) the resident's physician and, as appropriate, interdisciplinary care team, when transfer or discharge is necessary under subclause (1) or (2) of clause (a) of subparagraph (i) of this paragraph; and

(b) a physician when transfer or discharge is necessary due to the endangerment of the health of other individuals in the facility under subclause (3) of clause (a) of subparagraph (i) of this paragraph;

(iii) before it transfers or discharges a resident:

(a) notify the resident and designated representative, if any, and, if known, family member of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner the resident and/or family member understand;

(b) record the reasons in the resident's clinical record; and

(c) include in the notice the items described in subparagraph (v) of this paragraph;

(iv) provide the notice of transfer or discharge required under subparagraph (iii) of this paragraph at least 30 days before the resident is transferred or discharged, except that notice shall be given as soon as practicable before transfer or discharge, but no later than the date on which a determination was made to transfer or discharge the resident, under the following circumstances:

(a) the safety of individuals in the facility would be endangered;

(b) the health of individuals in the facility would be endangered;

(c) the resident's health improves sufficiently to allow a more immediate transfer or discharge;

(d) an immediate transfer or discharge is required by the resident's urgent medical needs;

(e) the transfer or discharge is the result of a change in the level of medical care prescribed by the resident's physician; or

(f) the resident has not resided in facility for 30 days.

(v) include in the written notice specified in subparagraph (iii) of this paragraph the following:

(a) The reason for transfer or discharge;

(b) The specific regulations that support, or the change in Federal or State law that requires, the action;

(c) The effective date of transfer or discharge;

(d) The location to which the resident will be transferred or discharged;

(e) a statement that the resident has the right to appeal the action to the State Department of Health, which includes:

(1) an explanation of the individual's right to request an evidentiary hearing appealing the decision;

(2) the method by which an appeal may be obtained;

(3) in cases of an action based on a change in law, an explanation of the circumstances under which an appeal will be granted;

(4) an explanation that the resident may remain in the facility (except in cases of imminent danger) pending the appeal decision if the request for an appeal is made within 15 days of the date the resident received the notice of transfer/discharge;

(5) in cases of residents discharged/transferred due to imminent danger, a statement that the resident may return to the first available bed if he or she prevails at the hearing on appeal; and

(6) a statement that the resident may represent him or herself or use legal counsel, a relative, a friend, or other spokesman;

(f) the name, address and telephone number of the State long term care ombudsman;

(g) for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act;

(h) for nursing facility residents who are mentally ill, 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;

(vi) provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility in the form of a discharge plan which addresses the medical needs of the resident and how these will be met after discharge, and provide a discharge summary pursuant to section 415.11, subdivision (d) of this Title; and

(vii) permit the resident, their legal representative or health care agent the opportunity to participate in deciding where the resident will reside after discharge from the facility.

(2) The department shall grant an opportunity for a hearing to any resident who requests it because he or she believes the facility has erroneously determined that he or she must be transferred or discharged in accordance with the following:

(i) the resident has the right to:

(a) request a hearing to appeal the transfer or discharge notice at any time within 60 days from the date the notice of transfer or discharge is received by the resident;

(b) remain in the facility pending an appeal determination if the appeal request is made within 15 days of the date of receipt of the transfer or discharge notice;

(c) a post-transfer/discharge appeal determination if the resident did not request an appeal determination within 15 days of the date of receipt of the transfer or discharge notice;

(d) return to the facility to the first available semi-private bed if the resident wins the appeal, prior to admitting any other person to the facility; and

(e) represent him or herself, or use legal counsel, a relative, a friend or other spokesman.

(ii) The resident or the resident's representative as described in (2)(i)(e) of this paragraph must be given the opportunity to:

(a) examine at a reasonable time before the date of the hearing, at the facility, and during the hearing, at the place of the hearing:

(1) the contents of the resident's file including his/her medical records; and

(2) all documents and records to be used by the facility at the hearing on appeal;

(b) bring witnesses;

(c) establish all pertinent facts and circumstances;

(d) present an argument without undue interference; and

(e) question or refute any testimony or evidence, including the opportunity to confront and cross-examine adverse witnesses.

(iii) All hearings must be conducted in accordance with Article 3 of the State Administrative Procedure Act, and in accordance with the following:

(a) the presiding officer shall have the power to obtain medical assessments and psychosocial consultations, and the authority to issue subpoenas;

(b) the nursing home shall have the burden of proof that the discharge or transfer is/was necessary and the discharge plan appropriate;

(c) an administrative hearing must be scheduled within 90 days from the date of the request for a hearing on appeal; and

(d) the parties must be notified in writing of the decision and provided information on the right to seek review of the decision, if review is available.

(3) The facility shall establish and implement a bed-hold policy and a readmission policy that reflect at least the following:

(i) At the time of admission and again at the time of transfer for any reason, the facility shall verbally inform and provide written information to the resident and the designated representative that specifies:

(a) the duration of the bed-hold policy during which the resident is permitted to return and resume residence in the facility; and

(b) the facility's policies regarding bed-hold periods, which must be consistent with subparagraph (iii) of this paragraph, permitting a resident to return.

(ii) At the time of transfer of a resident for hospitalization or for therapeutic leave, a nursing home shall provide written notice to the resident and the designated representative, which specifies the duration of the bed-hold policy described in subparagraph (i) of this paragraph.

(iii) A nursing home shall 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 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 Medicaid nursing home services.

(iv) A nursing home shall establish and follow a written policy under which a resident who has resided in the nursing home for 30 days or more and who has been hospitalized or who has been transferred or discharged on therapeutic leave without being given a bed-hold is readmitted to the facility 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 Medicaid nursing home services

(4) With regard to the assurance of equal access to quality care, the facility shall establish and maintain identical policies and practices regarding transfer, discharge and the provision of all required services for all individuals regardless of source of payment.

Appendix II: Federal Nursing Home Transfer/Discharge Requirements

Transfer & Discharge Protections [42 CFR 483.15(c), F-622]

The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless:

- a. *The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;*
- 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;*
- 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 to have paid under Medicare or Medicaid) a stay at the facility;*
- f. *The facility ceases to operate.*

Right to Appeal

The facility may not transfer or discharge the resident while the appeal is pending... unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. [See <http://ltcombudsman.org/issues/transfer-discharge#what> for more information.]

Documentation Required

When the facility transfers or discharges a resident under any of the circumstances specified [above]..., the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.

Documentation in the resident's medical record must include:

- a. *The basis for the transfer...*
- b. *When a resident is being transferred because the facility says it cannot meet the needs of a resident, 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).*

Notice before Transfer [42 CFR 483.15(c), F-623]

Before a facility transfers a resident, it must provide:

- a. Written notice to the resident and his/her representative in language and manner that they can understand;
- b. Notice must be given at least 30 days in advance. (With very limited exceptions, such as when a resident cannot be cared for safely or is a danger to others, in which case “notice shall be given as soon as practicable before transfer or discharge” and the facility must document the danger that failure to transfer/discharge would impose.)

Orientation for Transfer or Discharge [42 CFR 483.15(c), F-624]

A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

This orientation must be provided in a form and manner that the resident can understand.