Welcome to LTCCC's Monthly Webinar

Virtual Meeting Tips

- Submit **questions in the Q&A** at the bottom of Zoom screen
- Use chat at the bottom of Zoom screen for **comments** and conversation
- If you are having technical issues, please let us know in the chat and we will do our best to assist you

New at NursingHome411

- Senior Care Policy Brief: Justice Department Targets Health Care Fraud
- LTCCC Alert: Explore Nursing Home Deficiencies and Penalties Data
- January 2025 Webinar: Weeding Out Medicaid Fraud
- LTCCC Alert: For-Profit Nursing Homes Dominate Problem Facilities, New Data Show

Sign up for LTCCC alerts using QR code above or visit **nursinghome411.org/join**.

For materials from today's webinar, visit nursinghome411.org/webinar-nh-update.

Today's Webinar:

LONG TERM CARE COMMUNITY COALITION

LTCCC WEBINAR

2025 Nursing Home Update

Tuesday, February 18, 2024 | 1-2PM ET

Join healthcare data analyst **Robert McLaughlin** and LTCCC Executive Director **Richard Mollot** for an insightful two-part webinar. First, explore a new, improved methodology for assessing nurse staffing adequacy in nursing homes. Second, delve into new LTCCC resources aimed at safeguarding residents from improper transfers and discharges.

For materials from today's webinar, visit nursinghome411.org/webinar-nh-update.

The Long Term Care Community Coalition

- **LTCCC** is a nonprofit, nonpartisan organization dedicated to improving care & quality of life for the elderly & adult disabled in long-term care (LTC).
- **What we do**:
  - Policy research & analysis;
  - Systems advocacy;
  - Public education;
  - Home to two local LTC Ombudsman Programs.

www.nursinghome411.org

Presenter

Robert McLaughlin is a healthcare data analyst with a decade of experience uncovering operational, financial, and staffing issues in the healthcare system. His insights have aided advocates, policymakers, and legal teams in identifying deficiencies and improving accountability for seniors and people with disabilities. As an expert witness, Robert has provided pivotal testimony in elder abuse cases—including one that led to a landmark verdict—underscoring his commitment to raising care standards and enhancing transparency across the industry.

Brief Background on Nursing Home Staffing

Federal Staffing Requirements Under the 1987 Nursing Home Reform Law

Nursing homes 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,
- as determined by resident assessments and individual plans of care and
- considering the number, acuity and diagnoses of the facility's resident population.

The Problem

Too many nursing homes provide substandard care and inhumane conditions because inadequate staffing and its harmful impacts on residents are not adequately enforced.

According to LTCCC's 2021 report on nursing home oversight,

- **Staffing Citations are Rare**. Though approximately 75% of nursing homes have less staffing than needed to meet resident needs (according to a landmark federal study), only 1% of citations are for inadequate staffing.
- **Citations Rarely Lead to a Penalty**. Approximately 95% of citations for violating minimum care standards are cited at a level of "no harm." As a result, it is extremely unlikely that the facility will face a fine or any penalty whatsoever.

Result: Operators know that they can generally get away with inadequate staffing and poor care.

Addressing the Problem

- **Quantitative Staffing Standards**.
  - Many states have implemented specific numerical requirements for nurse staffing. For example, a state may require that nursing homes have a certain number of nursing staff per resident per day.
  - In 2024, CMS promulgated numerical requirements, including 3.48 hours of nurse staffing time per resident per day. These requirements will not go into effect for a couple of years and are facing numerous challenges
  - Note: **Any quantitative requirement is in addition to, not instead of, the longstanding federal requirement to provide sufficient staffing** to meet residents' needs.

- **Public Information on Staffing & Quality**.
  - Nursing Home Care Compare 5-Star Rating System. www.medicare.gov/care-compare/
  - PBJ reporting system. Every nursing home is required to report its staffing for a range of nursing and non-nursing staff for every day, based upon auditable payroll records.
    - CMS posts these data at www.data.cms.gov/.
    - LTCCC provides sortable and searchable files on nursing home staffing at www.nursinghome411.org/data/staffing/.

The Issue We're Addressing Today

The CMS system for calculating staffing ratings is deeply flawed

The Nursing Home Care Compare website compares reported staffing levels to state average staffing levels.

This has absolutely nothing to do with quality or safety.

Would you want to go to an average nursing home?

This methodology can result in facilities with poor staffing receiving higher ratings.

Aligning Resident Needs and Staffing: An Acuity-Based Approach for Nursing Homes

- **Robert McLaughlin | February 18th, 2025**

Agenda

1. Understanding the Case-Mix Index (CMI) Under PDPM
2. How the Five-Star Staffing System Uses CMI
3. Identifying Key Flaws in the Five-Star Staffing System
4. Proposing a New, Acuity-Based Methodology
5. Benefits and Implications

Case-Mix Index (CMI) Under PDPM

- **What is PDPM?**
  - A payment model that divides residents' care into five components, each with its own CMI:
    - *Physical Therapy (PT)*
    - *Occupational Therapy (OT)*
    - *Speech-Language Pathology (SLP)*
    - ***Nursing***
    - *Non-Therapy Ancillary*
- **How are CMIs Calculated?**
  - **PDPM Algorithms**: Each component (PT, OT/SLP, Nursing, NTA) has its own "recipe" of weighted items from MDS data.
  - **Result**: Each "case mix group" corresponds to a specific CMI, reflecting the resource intensity and expected care needs of residents.

Nursing CMI

- **Nursing Component**:
  - Based on MDS data capturing clinical complexity (e.g., ADL deficits, behavioral issues, medical conditions).
  - Outcome: A Nursing CMI that reflects the expected amount of nursing care.

How the Five-Star Staffing System Uses CMI

- **Collect Data**
  - Staffing data from the PBJ system
  - Resident acuity measured by CMI
- **Calculate CMI Ratio**
  - Facility's average CMI ÷ national average CMI
- **Determine "Case-Mix Hours"**
  - CMI ratio × national average hours per resident day (HPRD) (for RNs and total nursing)
- **Compute "Adjusted Hours"**
  - (Facility's reported HPRD ÷ facility's Case-Mix HPRD) × national average Case-Mix HPRD

How the Five-Star Staffing System Uses CMI

Key Takeaways:

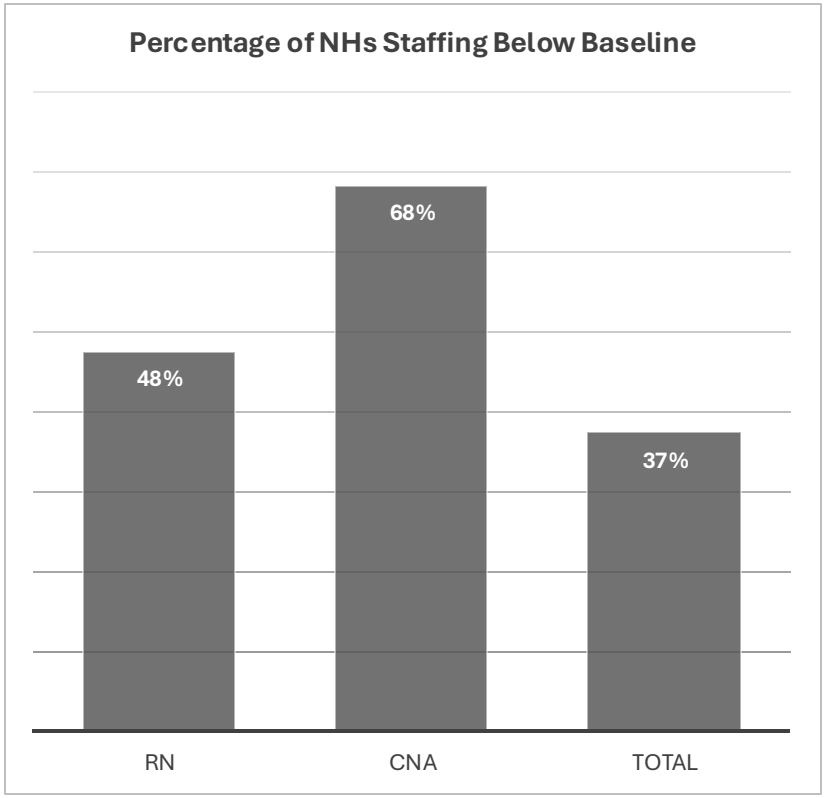
✓ **Case-Mix Hours set staffing expectations**, but these expectations are tied to nationwide norms—not care needs.
✓ **Adjusted Hours are not a real measurement of time**, rather a metric for ranking facilities and assigning scores.
✓ **Facilities are ranked in deciles**, with the top 10% earning 100 points, the next 10% earning 90, and so on.

Issues with the Current Five-Star Methodology

- Nationwide Staffing Norms Set Too Low
- High Ratings Despite Inadequate Staffing
- Misleading for Consumers
- Lack of Incentive to Improve

Nationwide Staffing Norms Set Too Low

- **2023 Study: Baseline Staffing Levels:**
  - RN: 0.55 HPRD
  - CNA: 2.45 HPRD
  - Total: 3.48 HPRD
- **2024 Reality:**
  - 48% of NHs fall below the RN baseline
  - 68% fall below the CNA baseline
  - 37% fall below the Total baseline

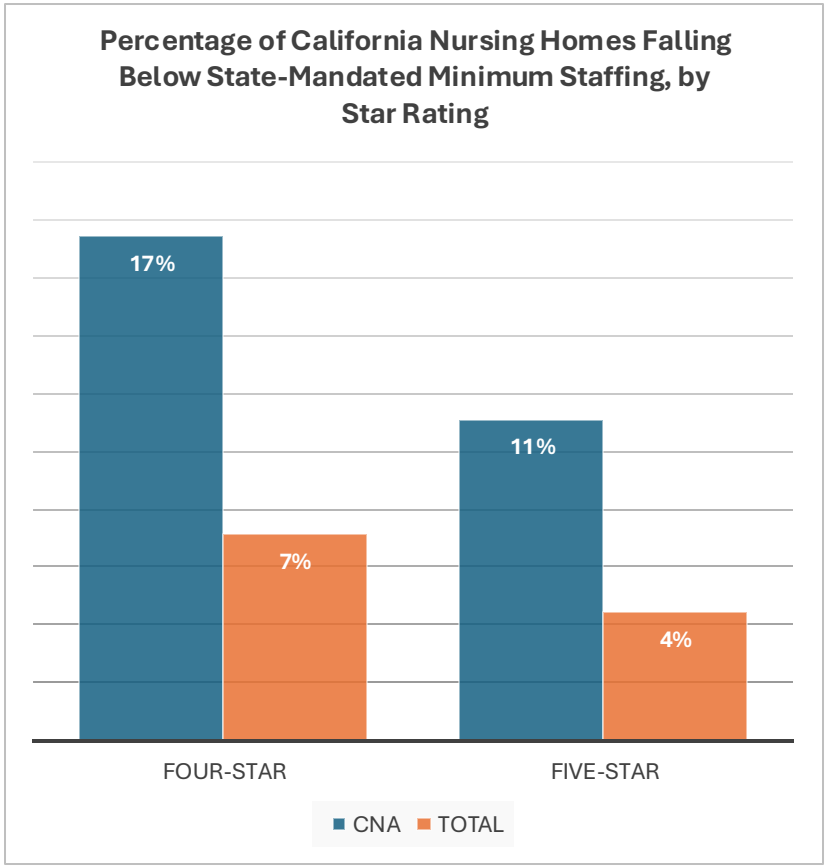


Source: Centers for Medicare & Medicaid Services (CMS). (December 2024). Provider Info file.

High Ratings Despite Inadequate Staffing

- **Q3 2024 California Data Highlights:**
  - Among Four-Star Facilities:
    - *17% fall below CNA baseline*
    - *7% fall below total baseline*
  - Among Five-Star Facilities:
    - *11% fall below CNA baseline*
    - *4% fall below total baseline*

- **Implication:** Even top-rated facilities may not staff sufficiently, contributing to a disconnect between star ratings and actual care.



Misleading for Consumers

- **Normalization of Low Staffing**
  - Ratings are based on comparisons to national averages, which are already below evidence-based standards.
- **Inflated Perceptions of Care**
  - Facilities can earn a high star rating despite falling below minimum thresholds.

Lack of Incentives for Improvement

- **Current Ratings Reward “Average”**
  - Facilities that merely match or slightly exceed the low national average can achieve high ratings.
- **No Direct Reward for Exceeding Baselines**
  - Meeting or surpassing evidence-based staffing thresholds is not distinctly recognized by the current system.

Summary of Key Issues

- The Five-Star Staffing system measures facilities against each other, rather than against clinical standards or actual resident acuity.
- Ratings can be high even with inadequate staffing
- Consumers receive incomplete information
- Facilities lack inventives to invest in better staffing

New Staffing Benchmark — Concept & Objectives

- **Link Staffing to Acuity**: Use facility- and resident-specific CMIs, not just national averages.
- **Dynamic Targets**: Staffing expectations rise or fall depending on the actual care needs of residents.
- **Clear Benchmarking**: Provide a straightforward way to compare reported staffing against an acuity-adjusted target.

Core Formula for “Case-Mix Hours”

- **Core Formula**: $Case\ Mix\ Hours = Minimum\ Staffing \times \left[1 + \beta \times \left(\left(\frac{Facility\ CMI}{Minimum\ CMI}\right) - 1\right)^{\gamma}\right]$

- **Key Definitions:**
  - **Baseline**: The minimum staffing level for low-acuity residents (e.g., 3.48 Total HPRD, 0.55 RN HPRD).
  - **Facility CMI**: A composite measure of resident acuity.
  - **Minimum CMI**: The reference CMI (0.62) for the lowest-acuity classification.
  - **β & γ**: Parameters (e.g., β ≈ 0.381 and γ = 0.7 for Total HPRD) that scale staffing needs as acuity rises.

How the Formula Translates in Practice

- **At Lowest-Acuity (CMI = 0.62)**
  - Case-Mix Hours = 3.48 total HPRD (2023 Study)
- **At Highest-Acuity (CMI = 3.84)**
  - Case-Mix Hours = 7.68 total HPRD (Time and Motion/Schnelle)
- **Sliding Scale**
  - For CMIs between 0.62 and 3.84, expected staffing adjusts proportionally.

Assessing Facility Performance Based on Publicly Available Data

- **General use of the methodology:**
  - In July 2024, CMS began incorporating facility-weighted average CMI in their Five-Star dataset, providing a more accurate representation of resident acuity.
  - This weighted average CMI can be used in the formula to calculate a benchmark for the time a facility was expected to staff.
  - PBJ data can then be used to compare the expected staffing vs. the levels reportedly provided by the facility.
- **Implication**: The data is publicly available and easily accessible, so anyone can calculate these benchmarks.

Assessing Facility Performance Based on Publicly Available Data (Example)

CCN	Nursing CMI	Case-Mix Total HPPD	Reported Total HPPD
465179	3.54	7.41	7.99
245405	1.08	4.56	4.75
315463	1.75	5.50	3.46
555718	1.55	5.24	5.84
555522	3.30	7.18	4.68
125024	1.45	5.11	3.27
15133	1.41	5.05	2.78
366405	1.64	5.36	6.18
265764	1.43	5.07	5.09
365470	1.38	5.01	4.91

Assessing Facility Performance Based on Publicly Available Data (Example Cont.)

CCN	Nursing CMI	Case-Mix Total HPPD	Reported Total HPPD	% Difference
465179	3.54	7.41	7.99	8%
245405	1.08	4.56	4.75	4%
315463	1.75	5.50	3.46	-37%
555718	1.55	5.24	5.84	11%
555522	3.30	7.18	4.68	-35%
125024	1.45	5.11	3.27	-36%
15133	1.41	5.05	2.78	-45%
366405	1.64	5.36	6.18	15%
265764	1.43	5.07	5.09	0%
365470	1.38	5.01	4.91	-2%

Assessing Facility Performance Based on Publicly Available Data (Example Cont.)

CCN	Nursing CMI	Case-Mix Total HPPD	Reported Total HPPD	% Difference	Percentile
465179	3.54	7.41	7.99	8%	78%
245405	1.08	4.56	4.75	4%	67%
315463	1.75	5.50	3.46	-37%	11%
555718	1.55	5.24	5.84	11%	89%
555522	3.30	7.18	4.68	-35%	33%
125024	1.45	5.11	3.27	-36%	22%
15133	1.41	5.05	2.78	-45%	0%
366405	1.64	5.36	6.18	15%	100%
265764	1.43	5.07	5.09	0%	56%
365470	1.38	5.01	4.91	-2%	44%

Five-Star Application

- **Reimagining the Staffing Ratings**
  - **Five Stars**: Awarded when both RN and total reported staffing meet or exceed the case-mix benchmarks.
  - **Four Stars:** Earned when one staffing category meets or exceeds its case-mix benchmark, while the other at least meets the baseline staffing standard (e.g., RN ≥ 0.55 HPRD and Total ≥ 3.48 HPRD).
  - **Three Stars**: Assigned when both staffing categories meet the baseline standards but neither reaches the case-mix benchmark.
  - **Two Stars**: Given if one staffing category falls below the baseline standard, regardless of the performance of the other category.
  - **One Star**: Designated if both RN and total reported staffing fall below the baseline staffing standard.
- **Implication**: Legitimize the rating system and recognize the NHs that prioritize resident care.

Facility-Level Application

- **Practical use in NHs**
  - **Leverage PDPM Group CMIs**
    - *Each PDPM group has a precalculated time.*
  - **Multiply by Resident Counts**
    - *For each group, multiply the preset time by the number of residents.*
  - **Average the Totals**
    - *Sum the products and divide by total residents to find the facility-wide benchmark.*
- **Implication**: Facilities don't need to do complex math: standard values can be plugged in based on PDPM groups.

	PDPM Group	Case-Mix Index	TOTAL Case-Mix Hours
Extensive Services	ES3	3.84	7.68
	ES2	2.90	6.78
	ES1	2.77	6.65
Special Care High	HDE2	2.27	6.11
	HDE1	1.88	5.66
	HBC2	2.12	5.94
	HBC1	1.76	5.51
Special Care Low	LDE2	1.97	5.77
	LDE1	1.64	5.36
	LBC2	1.63	5.35
	LBC1	1.35	4.97
Clinically Complex	CDE2	1.76	5.51
	CDE1	1.53	5.21
	CBC2	1.47	5.13
	CA2	1.03	4.47
	CBC1	1.27	4.85
	CA1	0.89	4.22
Behavioral Symptoms	BAB2	0.98	4.39
	BAB1	0.94	4.31
Reduced Physical Function	PDE2	1.48	5.15
	PDE1	1.39	5.02
	PBC2	1.15	4.67
	PA2	0.67	3.71
	PBC1	1.07	4.54
	PA1	0.62	3.48

Benefits of the Proposed Methodology

- **Transparent, Acuity-Adjusted Measurement**
- **Incentives to Exceed Baselines**
- **Enhanced Accountability & Continuous Improvement**
- **Ease of Verification**

Conclusion

- **Recap**
  - Current system is misaligned, using national averages vs. real acuity.
  - Proposed approach adjusts staffing targets to match actual resident needs.
  - Public data (Five-Star CMI + PBJ) enables transparent evaluation by all stakeholders.

How This Methodology Can Be Used

- **Public**. This information can be used to gain insights into the sufficiency of staffing in your nursing home and those in your community.
- **Government**. CMS and the states could use this methodology to improve the information provided to the public on nursing home quality & safety.
- **Nursing Homes**. Facilities can evaluate and plan their staffing based on the needs of their residents.
- **Attorneys**. Both public and private attorneys can use this information to identify inadequate staffing.

www.nursinghome411.org/data/ratings-info/

Provider Name	Nursing Case-Mix Index	Expected Total Nurse Staff Hours Per Resident Day (HPRD)	Expected RN HPRD	Reported Total Nurse Staff HPRD	Reported RN HPRD	Reported LPN HPRD	Reported Nurse Aide HPRD	Reported Total Nurse Staff HPRD on Weekend	Reported RN HPRD on Weekend
AUBURN REHABILITATION & NURSING CENTER	1.20	4.75	1.11	3.16	0.47	0.67	2.02	2.70	0.34
BEECHTREE CENTER FOR REHABILITATION AND NURSING	1.41	5.05	1.24	3.15	0.40	0.78	1.97	2.74	0.28
BETSY ROSS REHABILITATION CENTER, INC	1.53	5.21	1.31	3.57	0.38	0.98	2.21	3.28	0.19
BEZALEL REHABILITATION AND NURSING CENTER	1.40	5.04	1.23	3.07	0.51	0.52	2.04	2.73	0.32
BRIARCLIFF MANOR CENTER FOR REHAB AND NURSING CARE	1.44	5.09	1.25	3.16	0.27	1.02	1.87	2.84	0.15
BROOKLYN CTR FOR REHAB AND RESIDENTIAL HEALTH CARE	1.49	5.16	1.29	3.82	0.35	0.94	2.53	3.21	0.14
BROOKLYN UNITED METHODIST CHURCH HOME									
BROOKLYN-QUEENS NURSING HOME	1.34	4.96	1.20	3.69	0.50	0.91	2.27	3.18	0.32
CAMPBELL HALL REHABILITATION CENTER INC	1.44	5.10	1.26	3.04	0.26	0.84	1.94	2.48	0.15
CARTHAGE CENTER FOR REHABILITATION AND NURSING	1.39	5.02	1.22	3.48	0.41	0.86	2.21	2.79	0.26
CASA PROMESA	0.95	4.32	0.92	3.43	0.43	0.89	2.11	2.93	0.29
CAYUGA NURSING AND REHABILITATION CENTER	1.34	4.95	1.19	3.76	0.30	1.00	2.46	2.96	0.12
CENTRAL PARK REHABILITATION AND NURSING CENTER	1.17	4.71	1.09	3.82	0.49	0.97	2.36	3.24	0.22
CENTRAL QUEENS REHAB & NURSING CENTER	1.41	5.05	1.24	2.90	0.40	0.58	1.92	2.40	0.15
CHASEHEALTH REHAB AND RESIDENTIAL CARE	1.17	4.70	1.09	2.75	0.28	0.83	1.63	2.33	0.11
CLINTON COUNTY NURSING HOME	1.37	5.00	1.22	4.10	0.78	1.00	2.32	3.39	0.63
COLD SPRING HILLS CENTER FOR NURSING AND REHAB	1.36	4.98	1.21	4.64	0.61	0.77	3.26	4.23	0.39
COLONIAL PARK REHABILITATION AND NURSING CENTER	1.48	5.15	1.28	3.17	0.52	1.03	1.62	3.00	0.29
COMPREHENSIVE REHAB & NURSING CTR AT WILLIAMSVILLE	1.13	4.64	1.06	3.77	0.37	1.13	2.28	3.33	0.26
COOPERSTOWN CENTER FOR REHABILITATION AND NURSING	1.26	4.84	1.14	3.62	0.31	1.11	2.21	3.20	0.10
CORTLAND PARK REHABILITATION AND NURSING CENTER	1.24	4.80	1.13	3.17	0.25	1.06	1.86	2.73	0.16
CREST MANOR LIVING AND REHABILITATION CENTER	1.45	5.11	1.26	3.48	0.49	1.13	1.86	2.94	0.10
DELHI REHABILITATION AND NURSING CENTER	1.06	4.52	1.01	3.23	0.27	0.91	2.04	2.87	0.11
DELMAR CENTER FOR REHABILITATION AND NURSING	1.40	5.03	1.23	3.48	0.50	1.01	1.96	2.86	0.25
DUNKIRK REHABILITATION & NURSING CENTER	1.12	4.62	1.05	3.25	0.43	0.89	1.92	3.01	0.24
EDDY HERITAGE HOUSE NURSING AND REHABILITATION CTR	1.38	5.00	1.22	4.13	0.83	1.17	2.13	3.36	0.38
ELDERWOOD AT AMHERST	1.27	4.85	1.15	3.96	0.67	0.98	2.32	3.51	0.52
ELLICOTT CENTER FOR REHABILITATION AND NURSING	1.40	5.03	1.23	3.89	0.35	1.12	2.43	3.13	0.20
ELM MANOR NURSING AND REHABILITATION CENTER	1.33	4.94	1.19	2.90	0.32	1.17	1.40	2.55	0.29
ESSEX CENTER FOR REHABILITATION AND HEALTHCARE	1.23	4.80	1.13	2.90	0.39	0.89	1.62	2.59	0.15
FAR ROCKAWAY CENTER FOR REHABILITATION AND NURSING	1.37	4.99	1.21	2.66	0.27	0.64	1.74	2.23	0.18
FERNCLIFF NURSING HOME CO INC	1.24	4.80	1.13	3.32	0.45	0.66	2.21	2.84	0.30
FIELDSTON LODGE CARE CENTER	1.41	5.06	1.24	3.81	1.39	0.31	2.11	3.16	1.03


Questions?
Comments?

New Federal Transfer & Discharge Protections

Effective March 24, 2025

Why Are We Concerned About Transfer & Discharge Rights?

- Inappropriate discharges from nursing homes are a widespread and persistent problem.

- Too many nursing homes dump residents…
  - when their Medicare benefits run out or
  - If they are perceived as “difficult” or
  - If they require more care than the facility wishes to provide.

- Examples of inappropriate discharges
  - Sending a resident to the hospital and then refusing to take them back, even though they still need the nursing home’s care;
  - Telling a resident who complains about call bell response time that it sounds like they don’t want to be in the facility and putting them in a taxi to their son’s house;
  - Telling a daughter that her mother has become “difficult” and she needs to take her someplace else this week.

- Under longstanding federal rules, a resident can only be transferred or discharged if:

a. The transfer/discharge is necessary for the resident's welfare and needs cannot be met in the facility.
b. The resident’s health has improved so they no longer need the facility's services.
c. The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident.
d. The health of others in the facility would be otherwise endangered.
e. The resident has failed to pay after reasonable notice.
f. The facility ceases to operate.

Documentation Requirements

A nursing home cannot just cite one of these reasons and that's the end of the story.

- It must ensure that the transfer or discharge is properly 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:
  1. The basis for the transfer….
  2. 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 special services available at the receiving facility to meet the need(s).

Documentation must be made by the resident's physician for reasons a. and b. and by a physician for reasons c. and d. listed on previous slide.

Orientation for Transfer & Discharge

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

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

Notice of Bed-Hold Policy

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—

a. *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;*
b. *The reserve bed payment policy in the state plan…, if any;*
c. *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*
d. *The information specified in paragraph (e)(1) of this section*.

Note: Paragraph (e)(1) require facilities to permit residents to return to the facility immediately to the first available bed in a semi-private room.

Right to Appeal Transfer or Discharge

- Residents have the right to appeal a transfer or discharge decision.
- Facility must not transfer or discharge a resident while an appeal is pending.
  - **Exception**: If remaining in the facility endangers the health or safety of the resident or others, the facility must document the risk.
  - If claiming this exception, the facility must document the danger that failure to transfer or discharge would pose.
- Residents must be informed of their appeal rights in writing, including contact details for state agencies and ombudsman services.
- Resources: Residents can seek assistance from legal aid, ombudsman programs, and advocacy organizations.

Transfer/Discharge Notice

Before a facility transfers/discharges a resident, it **must** provide:

a. Written notice to the resident and his/her representative in language and manner that they can understand;

b. Record the reasons for the transfer or discharge in the resident's medical record

c. 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.)

d. The facility must send a copy of the notice to… the State Long-Term Care Ombudsman.

Required Contents of the Notice

The transfer/discharge notice **must include all of the following at the time notice is provided**:

a. The **specific reason** for the transfer or discharge (including the basis under the six permissible reasons described earlier);

b. The **effective date** of the transfer or discharge;

c. The **specific location** (such as the name of the new provider or description and/or address if the location is a residence) to which the resident is to be transferred or discharged;

d. 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;

e. The name, address (mailing and email) and telephone number of the Office of the **State Long-Term Care Ombudsman**.

Note: Residents with intellectual and developmental disabilities (or related disabilities) and those with a mental disorder (or related disabilities) must also receive the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with those conditions.

Requirements Related to the LTCOP

The updated guidance strongly reflects the important role that LTC Ombudsmen have in

1. Protecting residents,
2. Assisting residents and their families, and
3. Monitoring nursing home care and practices.

Highlights:

- All discharge notices must be sent to the LTCOP.
- Discharge notices must be sent to the LTCOP at the same time as they are provided to the resident (except in an emergency discharge/transfer situation).
- Surveyors should reach out to the LTCOP "*to identify residents or resident representatives (for residents already discharged) who may have concerns with inappropriate discharges.*"

The intent of sending copies of the notice to a representative of the Office of the State LTC Ombudsman is to provide added protection to residents from being inappropriately transferred or discharged, provide residents with access to an advocate who can inform them of their options and rights, and to ensure that the Office of the State LTC Ombudsman is aware of facility practices and activities related to transfers and discharges.

Fact Sheet 1: Essential Protections, Documentation, and Right to Appeal

LONG TERM CARE
COMMUNITY COALITION
Advancing Quality, Dignity & Justice

TRANSFER & DISCHARGE RIGHTS I

ESSENTIAL PROTECTIONS, DOCUMENTATION, & RIGHT TO APPEAL REQUIREMENTS

FACT SHEET

The threat of transfer or discharge from a nursing home can be stressful, frightening, and dangerous. For these reasons, there are significant federal protections that limit the circumstances under which residents can be transferred or discharged from their facility.

This fact sheet provides user-friendly information and excerpts from the federal requirements and guidance on discharge and transfer protections. **Please see our fact sheet, *Transfer & Discharge Rights II*,** for information on right to return following hospitalization, discharge planning, and notice of bed-hold and transfer/discharge policies requirements. For the complete federal guidance on transfer and discharge rights, visit nursinghome411.org/discharge.

Note: The brackets below provide, for reference, the citation to the federal requirement (42 CFR 483.xx) and the F-tag number used when a facility is cited for failing to meet the requirement.

I. Transfer & Discharge Protections [42 CFR 483.15(c) F-627]

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.*

II. Right to Appeal [42 CFR 483.15(c)(1)(ii) F-627]

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.]

III. Documentation Requirements [42 CFR 483.15(c)(2) F-627]

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).*

Documentation must be made by the resident's physician for reasons I.a. and I.b., above, and by a physician for reasons I.c. and I.d., above.

NOTE: Except in very limited circumstances, a facility must provide notice 30 days in advance of a discharge. See our fact sheet, ***Transfer & Discharge Rights II***, for detailed information on notice requirements for a facility's bed-hold, transfer and discharge policies**.**

EXAMPLES OF NON-COMPLIANCE WITH TRANSFER & DISCHARGE REQUIREMENTS

When evidence in the medical record does not support the basis for discharge, such as:

- *Discharge based on an inability to meet the resident's needs, but there is no evidence of facility attempts to meet the resident's needs, or no evidence of an assessment at the time of discharge indicating what needs cannot be met;*
- *Discharge based on improvement of resident's health such that the services provided by the facility are no longer needed, but documentation shows the resident's health did not improve or actually declined;*
- *Discharge based on the endangerment of the safety or health of individuals in the facility, but there is no documentation in the resident's medical record that supports this discharge;*
- *Discharge based on failure to pay, however there is no evidence that the facility offered the resident to pay privately or apply for Medical Assistance or that the resident refused to pay or have paid under Medicare or Medicaid;*
- *Discharge occurs even though the resident appealed the discharge, the appeal is pending, and there is no documentation to support the failure to discharge would endanger the health and safety of individuals in the facility.*

When evidence in the medical record shows a resident was not permitted to return following hospitalization or therapeutic leave, and there is no valid basis for discharge.

There is no evidence that the facility considered the care giver's availability, capacity, and/or capability to perform needed care to the resident following discharge.

The post-discharge plan of care did not address resident limitations in ability to care for themself.

Fact Sheet 2: Right to Return to Facility; Notice Requirements for Bed-Hold, Transfer and Discharge

LONG TERM CARE
COMMUNITY COALITION
Advancing Quality, Dignity & Justice

TRANSFER & DISCHARGE RIGHTS II
RIGHT TO RETURN; NOTICE REQUIREMENTS FOR BED-HOLD, TRANSFER & DISCHARGE
FACT SHEET

The threat of transfer or discharge from a nursing home can be stressful and frightening to a resident and his or her family. Our fact sheet, *Transfer & Discharge Rights I,* discusses fundamental resident protections, the right to appeal, and documentation requirements. This fact sheet presents additional useful information on resident rights. For the complete federal guidance on transfer and discharge rights, visit nursinghome411.org/discharge.

Notes: The brackets below provide, for reference, the citation to the federal requirement (42 CFR 483.xx) and the F-tag number used when a facility is cited for failing to meet the requirement. Emphases (bold) have been added by LTCCC.

I. Permitting Residents to Return to Facility [42 CFR 483.15(e)(1) F-627]

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) [above] *as they apply to discharges.*

II. Orientation for Transfer or Discharge [42 CFR 483.15(c) F-627]

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.

III. Notice of Bed-Hold Policy [42 CFR 483.15(d) F-628]

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—

a. *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;*
b. *The reserve bed payment policy in the state plan…, if any;*

c. *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*
d. *The information specified in paragraph (e)(1) of this section.*

Note: Paragraph (e)(1) require facilities to permit residents to return to the facility immediately to the first available bed in a semi-private room.

IV. Notice Before Transfer or Discharge [42 CFR 483.15(c)(2) F-628]

Before a facility transfers/discharges a resident, it **must** provide:

a. Written notice to the resident and his/her representative in language and manner that they can understand;
b. Record the reasons for the transfer or discharge in the resident's medical record
c. 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.)
d. The facility must send a copy of the notice to… the State Long-Term Care Ombudsman.

V. Contents of the Notice [42 CFR 483.15(c)(5) F-628]

The transfer/discharge notice **must include all of the following at the time notice is provided**:

a. The specific reason for the transfer or discharge, including the basis under §§483.15(c)(1)(i)(A)-(F);
b. The effective date of the transfer or discharge;
c. The specific location (such as the name of the new provider or description and/or address if the location is a residence) to which the resident is to be transferred or discharged;
d. 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;
e. The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman.

Note: Residents with intellectual and developmental disabilities (or related disabilities) and those with a mental disorder (or related disabilities) must also receive the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with those conditions.

VI. Timing of Notice [42 CFR 483.15(c)(4) F-628]

A notice of transfer or discharge must be made by the facility at least 30 days before the resident is transferred or discharged, except under the following circumstances: (1) The safety or health of individuals in the facility would be endangered, (2) The resident's health improves sufficiently to allow a more immediate transfer or discharge; (3) Immediate transfer or discharge is required by the resident's urgent medical needs; or (4) The resident has not resided in the facility for 30 days.

Fact Sheet 3: Special Information for LTC Ombudsmen

LONG TERM CARE
COMMUNITY COALITION
Advancing Quality, Dignity & Justice

TRANSFER & DISCHARGE RIGHTS III
INFORMATION FOR LTC OMBUDSMEN
FACT SHEET

The threat of transfer or discharge from a nursing home can be dangerous, stressful, and overwhelming for residents and their families. Our fact sheets, *Transfer & Discharge Rights I* and *Transfer & Discharge Rights II*, offer information on resident rights, including protections against facility-initiated discharges, notice requirements, and more.

Given the critical role ombudsmen play in protecting residents and helping them and their families, federal rules and guidelines address the special role of the LTC Ombudsman Program in cases of transfer or discharge. **This fact sheet focuses on the rules and guidance relevant to ombudsmen and the role they have in ensuring that facilities follow transfer & discharge requirements**. For the complete federal guidance on transfer and discharge rights, visit nursinghome411.org/discharge.

Notes: The brackets below provide, for reference, the citation to the federal requirement (42 CFR 483.xx) and the F-tag number used when a facility is cited for failing to meet the requirement. Emphases (bold) have been added by LTCCC.

Except in an emergency situation…
1. The discharge notice must be sent to the LTCOP at the same time it is provided to the resident.
2. Notices must be given at least 30 days in advance.

I. Notice Before Transfer [42 CFR 483.15(c)(2) F-628]

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.)
c. *The facility must send a copy of the notice to… the State Long-Term Care Ombudsman*.

Important Note: Previously, facilities were only required to send notice to the LTCOP when a discharge was initiated by the facility. Now, **all discharge notices must be sent to the LTCOP**. This is important because, too often, facilities inaccurately identify facility-initiated discharges as resident-initiated in order to avoid these important reporting requirements.

II. Notice of Transfer or Discharge & Ombudsman Notification [42 CFR 483.15(c)(3)]

When a facility transfers or discharges a resident, prior to the transfer or discharge, the facility must 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 intent of sending copies of the notice to a representative of the Office of the State LTC Ombudsman is to provide added protection to residents from being inappropriately transferred or

discharged, provide residents with access to an advocate who can inform them of their options and rights, and to ensure that the Office of the State LTC Ombudsman is aware of facility practices and activities related to transfers and discharges.

The facility must maintain evidence that the notice was sent to the Ombudsman. While Ombudsman Programs vary from state to state, facilities should know the process for ombudsman notification in their state. In situations where the facility has decided to discharge the resident while the resident is still hospitalized, the facility must send a notice of discharge to the resident and resident representative before the discharge, and must also send a copy of the discharge notice to a representative of the Office of the State LTC Ombudsman. ***Notice to the Office of the State LTC Ombudsman must occur at the same time the notice of discharge is provided to the resident and resident representative****, even though, at the time of initial emergency transfer, sending a copy of the transfer notice to the ombudsman only needed to occur as soon as practicable.* [Emphases added.]

III. Discharge Planning [§42 CFR 483.21(c)(1)

Discharge planning must include procedures for "[d]ocumentation of referrals to local contact agencies, the local ombudsman, or other appropriate entities made for this purpose… [and] [d]ocumentation of the response to referrals."

IV. Investigative Procedure for State Surveyors

Investigating noncompliance with the transfer and discharge requirements begins when conducting offsite preparation. ***The team coordinator (TC) should contact the local ombudsman*** *and inquire if there are specific residents from whom the ombudsman has received complaints related to inappropriate discharges for review….*

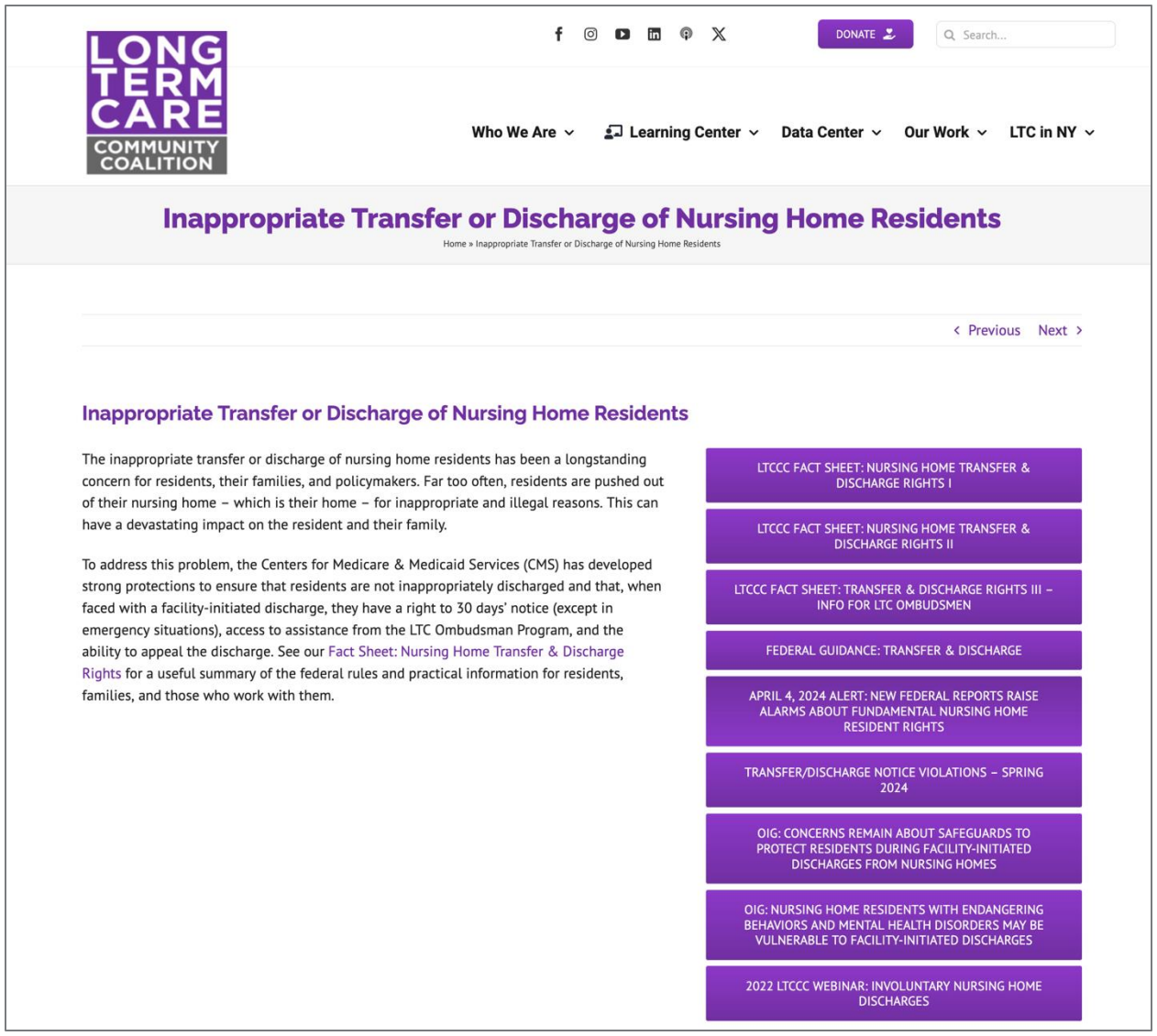
Use Offsite Preparation information from the Ombudsman to identify residents or resident representatives (for residents already discharged) who may have concerns with inappropriate discharges*. For any residents with concerns, briefly review the most recent comprehensive assessment, comprehensive care plan (specifically the discharge care plan), progress notes, and orders to:*

- *Identify the basis for the transfer or discharge,*
- *Determine whether the facility has identified and addressed the resident's goals and discharge needs;*
- *Determine if the resident was appropriately oriented, prepared, and understood the information provided to him or her.*

During this review, identify the extent to which the facility has developed and implemented interventions in accordance with the resident's needs, goals for care and professional standards of practice. This information will guide observations and interviews to be made in order to corroborate concerns identified.

Emergency Transfers*--When a resident is temporarily transferred on an emergency basis to an acute care facility a notice of transfer must be provided to the resident and resident representative as soon as practicable before the transfer, according to 42 CFR §483.15(c)(4)(ii)(D).* ***Copies of notices for emergency transfers must also still be sent to the ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis****, as long as the list meets all requirements for content of such notices at §483.15(c)(5).*

www.nursinghome411.org/discharges/



LTCCC's March Webinar

Topic: A Conversation With Nursing Home Residents

Date/Time: March 18 at 1pm ET

Register: bit.ly/mar-2025-webinar

Head to NursingHome411…

- Materials from today's webinar, https://nursinghome411.org/webinar-nh-update
- To find the staffing levels in the nursing homes in your state or community, https://nursinghome411.org/data/staffing
- Follow LTCCC on Instagram for updates, upcoming webinars, and more! @LTCcoalition
- Visit LTCCC's Learning Center for…
  - ✓ Fact sheets on key nursing home standards
  - ✓ Assisted living guides
  - ✓ Family empowerment resources
  - ✓ The Resident Abuse, Neglect, & Crime Reporting Center

Thank You For Joining!

For updates & invites to future programs: www.nursinghon

LTC Ombudsmen: Look out for an email confirming your attendance of this program on Thursday.

Questions?

Comments?