

Transfer and Discharge from the Facility - Overview Policy

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Transfer and Discharge from the Facility Policy

PREFACE

It is the policy of this facility that each resident has the right to remain in the facility and not transfer or discharge a resident unless a transfer or discharge from the facility is:

- Necessary for the resident's welfare and the resident's needs cannot be met in the facility
- The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
- The resident requires immediate transfer or discharge based on the residents urgent medical need
- 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;
- The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
- The health of individuals in the facility would otherwise be endangered;
- 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.
 - 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
- The facility ceases to operate.

The rights of residents who voluntarily or involuntarily are discharged from the facility will be upheld and that a resident will not be involuntarily discharged unless the circumstances meet specific criteria defined by regulations and laws. The facility will make every effort to provide care and services to the residents it serves.

Should a resident's need(s) not be met by the services provided by the facility, the facility staff will reevaluate the resident's care plan to determine if changes to the care plan will help meet the resident's needs. If the facility cannot provide for the resident's needs, the resident may have to be transferred to another healthcare facility that can provide the services needed for the resident. If the resident no longer needs the services of the facility because their health has improved, the facility may discharge the resident. In the event that a resident's clinical condition or behavior poses a health or safety threat to other people in the facility, the resident may be transferred to another healthcare facility that can provide the services needed for the resident.



The resident and representative will receive timely notification, adequate preparation, orientation and information to make the transfer as orderly and safe as possible. The notice contain information about the transfer and information about the resident's appeal rights. The facility will assist the resident to obtain, complete and submit an appeal form at the president's request. The resident will not be discharged during the appeal process. If the transfer is due to an emergency, the notice will be issued as soon as practicable. The facility forwards a copy all discharge notices to the Office of the State Long-Term Care Ombudsman and required state agencies (Insert state specific requirements)

OBJECTIVE OF TRANSFER AND DISCHARGE OVERVIEW POLICY

The objective of the transfer/discharge policy is to ensure that the resident is informed of an impending discharge and their right to appeal the discharge. In addition, the intent of this policy is to support each resident's right to voice concerns and refusal related to the impending discharge as well as notification of their appeal rights. The policy provides guidance to facility practices for identifying specific circumstances that allow a resident's involuntary transfer/discharge and stipulates the information provided in the discharge notice, the documentation in the resident's medical record and the information shared with the respective State Agencies per requirement.

State Agency Contact Information Related to Transfer and Discharges (Insert State Specific Agencies with contact information)

CENTERS FOR MEDICAID AND MEDICARE SERVICES (CMS) – DEFINITIONS

Resident representative. For purposes of this subpart, the term resident representative means any of the following:

- (1) An individual chosen by the resident to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications;
- (2) A person authorized by State or Federal law (including but not limited to agents under power of attorney, representative payees, and other fiduciaries) to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications;
- (3) Legal representative, as used in section 712 of the Older Americans Act; or.
- (4) The court-appointed guardian or conservator of a resident.
- (5) Nothing in this rule is intended to expand the scope of authority of any resident representative beyond that authority specifically authorized by the resident, State or Federal law, or a court of competent jurisdiction.

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“Anticipates” means that the discharge was not an emergency discharge (e.g., hospitalization for an acute condition) or due to the resident’s death.

Transfer and discharge includes 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 does not refer to movement of a resident to a bed within the same certified facility.

“Sufficient preparation” means the facility informs the resident where he or she is going and takes steps under its control to assure safe transportation. The facility should actively involve, to the extent possible, the resident and the resident’s family in selecting the new residence.

Equal Access to quality of care related to transfers - A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

OVERVIEW OF REGULATORY REQUIREMENT COMPONENTS FOR THIS POLICY

(c) *Transfer and discharge*—(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—

(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. 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.

(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.

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(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.

(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).

(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 (B) A physician when transfer or discharge is necessary under paragraph (b)(1)(i)(C) or (D) of this section.

(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 residents 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.

(3) *Notice before transfer.* Before a facility transfers or discharges a resident, the facility must—

(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. (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 (iii) Include in the notice the items described in paragraph (b)(5) of this section.

(4) *Timing of the notice.* (i) Except as specified in paragraphs (b)(4)(ii) and (b)(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. (ii) Notice must be made as soon as practicable before transfer or discharge when—

(A) The safety of individuals in the facility would be endangered under paragraph (b)(1)(ii)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (b)(1)(ii)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (b)(1)(ii)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (b)(1)(ii)(A) of this section; or (E) A resident has not resided in the facility for 30 days.

(5) *Contents of the notice.* The written notice specified in paragraph (b)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (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; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (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 U.S.C. 15001 *et seq.*); and (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.

(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.

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

(8) *Notice in advance of facility closure.* In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).

PROCEDURE

The facility will provide proper and timely notice to a resident who will be discharged as required by regulations and laws. The facility will work with the physician to obtain adequate documentation about the reason to discharge the resident. The facility will provide preparation and orientation to the resident, family and receiving facility prior to discharge. The appropriate State and Federal agencies will receive notice of a resident's involuntary discharges

A. Identification

- a. Facility staff continually monitors resident's health and well-being and the care provided to meet their needs. If a resident's condition changes significantly, the resident's physician or delegate is notified.
- b. The Interdisciplinary Team reviews changes in residents' status to determine if their health has improved or changed. Based upon clinical assessment there may arise few circumstances when the facility may issue a discharge notice to the resident: when the resident's health has improved and the resident no longer needs the services provided by the facility, when the resident's clinical condition or behavior poses a threat to the health or safety of others in the facility, when the resident's needs can no longer be met by the facility and if the resident has failed to pay for their stay or has failed to arrange for third party payment of their stay. If the facility ceases to operate all resident will receive a discharge notice.
 - i. The IDT discusses a resident's clinical status and discharge preferences and goals with the resident and representative from the time of admission.
 - ii. A member of the IDT periodically updates the resident's physician about the resident's status and/or progress toward discharge.
- c. If the resident's health has improved and they no longer need the services provided by the facility, but the resident does not wish to discharge, the IDT will inform the resident's physician. If the physician agrees, the IDT will seek an appropriate setting for the resident and issue a discharge notice to the resident.
- d. If a resident's clinical condition or behavior changes, the facility staff will inform the resident's physician and make every effort to assess the change and revise the resident's plan of care to meet their needs.
 - i. If the resident's condition or behavior poses a threat to the health or safety of other people in the facility, the facility may issue a discharge notice to the resident.
 - ii. If the resident's condition changes and the facility cannot provide the services needed to care for the resident,



- e. The facility will make every effort to work with residents to collect payment for services provided. If the resident does not make reasonable attempts to pay the outstanding bill by _____ days in arrears, the facility may issue a discharge notice.
- f. The facility will make every effort to assist residents and their representative to gather and submit information required by Medicaid, Medicare and other third party payers. If the resident or representative refuses to cooperate with the facility's efforts and does not provide the required information to the payer claims will be rejected and the resident's bill will not be paid. If the resident and/or representative do not take efforts to pay the bill within _____ days, the facility may issue a discharge notice

B. Timing of the notice

- a. The transfer/discharge notice will be issued with a discharge date at least 30 days before the resident is transferred or discharged.
 - i. The notice will be in a language and manner that the resident can understand.
 - ii. If the transfer/discharge was an emergency, the notice will be issues as soon as practicable when:
 - 1. The safety of the individuals in the facility would be endangered
 - 2. The health of the individuals in the facility would be endangered
 - 3. The resident's health improved sufficiently to allow a more immediate transfer or discharge
 - 4. An immediate transfer or discharge is required by the resident's urgent medical condition
 - 5. The resident has not resided in the facility for 30 days
- b. The social worker will review and explain the notice to the resident and their representative and discuss the resident's right to appeal the discharge. If the resident wishes to appeal the social worker will provide information and assistance to obtain, complete and submit the appeal request to (*insert the name of the State agency that receives these appeals.*)
- c. During the appeal process the resident will not be discharged.
- d. A copy of the discharge notice is sent to the State Office of Long Term Care Ombudsman. The Ombudsman office may offer additional support and advocacy to the resident.



- e. If information changes prior to the resident's discharge, the notice will be updated and distributed to all required parties.

C. Contents of the Notice

Before the facility will transfer or discharge a resident, the facility will provide a written notice to the resident and resident representative in a manner and language in which it is understood. The facility will send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman and identified state agencies per requirements.

The interdisciplinary team designee will meet with the resident and resident representative as applicable to review the Notice and its contents. At a minimum the notice will include:

- a. The reason for transfer/discharge
- b. The effective date of the transfer/discharge
- c. The location to which the resident will be transferred
- d. A statement of the resident's appeal rights
- e. The name, mailing address, email address and telephone number of the agency that receives discharge appeal requests
- f. Information about how to obtain an appeal form
- g. The title of the facility staff who will assist the resident to complete and submit the form
- h. The name, mailing address, email address and telephone number of the State Long Term Care Ombudsman's office.

D. Individuals with Intellectual and Development Disabilities

- a. The notice will contain the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities developmental, or related disabilities; the mailing address, email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities.

E. Individuals with a Mental Disorder or Related Disabilities

- a. The notice will contain the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a

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mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

F. (Illinois) Identified Offender

- a. *If, based on the security measures listed in the Identified Offender Report and Recommendation, a facility determines that it cannot manage the identified offender resident safely within the facility, it shall commence involuntary transfer or discharge proceedings pursuant to Section 3-402 of the Act and Section 300.3300 of this Part. (Section 2-201.6(g) of the Act)*
- b. *All discharges and transfers shall be pursuant to Section 300.3300 of this Part.*
- c. *When a resident who is an identified offender is discharged, the discharging facility shall notify the Department.*
- d. *A facility that admits or retains an identified offender shall have in place policies and procedures for the discharge of an identified offender for reasons related to the individual's status as an identified offender, including, but not limited to:*
 - 1) *The facility's inability to meet the needs of the resident, based on Section 300.625 of this Part and subsection (a) of this Section;*
 - 2) *The facility's inability to provide the security measures necessary to protect facility residents, staff and visitors; or*
 - 3) *The physical safety of the resident, other residents, the facility staff, or facility visitors.*
- e. *Discharge planning shall be included as part of the plan of care developed pursuant to Section 300.625(j). (Source: Amended at 35 Ill. Reg. 11419, effective June 29, 2011)*
- f. *When a resident who is an identified offender is transferred to another facility regulated by the Department, the Department of Healthcare and Family Services, or the Department of Human Services, the transferring facility shall notify the Department and the receiving facility that the individual is an identified offender before making the transfer.*
- g. *This notification shall include all of the documentation required under Section 300.625 of this Part and subsection (a) of this Section, and the transferring facility shall provide this information to the receiving facility to complete the discharge planning.*
- h. *If the following information has been provided to the transferring facility from the Department of Corrections, the transferring facility shall provide copies to the receiving facility before making the transfer:*
 - 1) *The mittimus and any pre-sentence investigation reports;*
 - 2) *The social evaluation prepared pursuant to Section 3-8-2 of the Unified Code of Corrections;*



- 3) *Any pre-release evaluation conducted pursuant to subsection (j) of Section 3-6-2 of the Unified Code of Corrections;*
 - 4) *Reports of disciplinary infractions and dispositions;*
 - 5) *Any parole plan, including orders issued by the Illinois Prisoner Review Board and any violation reports and dispositions; and*
 - 6) *The name and contact information for the assigned parole agent and parole supervisor. (Section 3-14-1 of the Unified Code of Corrections)*
- i. *The information required by this Section shall be provided upon transfer. Information compiled concerning an identified offender shall not be further disseminated except to the resident; the resident's legal representative; law enforcement agencies; the resident's parole or probation officer; the Division of Long Term Care Field Operations in the Department's Office of Health Care Regulation; other facilities licensed by the Department, the Illinois Department of Healthcare and Family Services, or the Illinois Department of Human Services that are or will be providing care to the resident, or are considering whether to do so; health care and social service providers licensed by the Illinois Department of Financial and Professional Regulation who are or will be providing care to the resident, or are considering whether to do so; health care facilities and providers in other states that are licensed and/or regulated in their home state and would be authorized to receive this information if they were in Illinois.*
(Source: Amended at 35 Ill. Reg. 11419, effective June 29, 2011)
- j. *When an identified offender is within the provisional admission period defined in Section 1-120.3 of the Act and Section 300.330 of this Part. If the Identified Offender Report and Recommendation prepared under Section 2-201.6 of the Act shows that the identified offender poses a serious threat or danger to the physical safety of other residents, the facility staff, or facility visitors in the admitting facility, and the facility determines that it is unable to provide a safe environment for the other residents, the facility staff, or facility visitors, the facility shall transfer or discharge the identified offender within 3 days after its receipt of the Identified Offender Report and Recommendation. (Section 3-402(c) of the Act)*

G. Changes to the Notice – if the information in the notice changes prior to effecting the transfer or discharge, the facility will update the recipients of the notice as soon as practicable once the updated information becomes available

H. Appeal Rights

- a. The facility will 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.

I. Documentation

a. The resident's physician and facility staff will document in the resident's record:

- i. The resident's health status at the time of notice
- ii. Reason that the services provided by the facility are no longer needed; document discharge needs and discharge plan
- iii. Date notice was received
- iv. Date copy of the notice was sent to the representative of the Office of the State Long-Term Care Ombudsman and identified state agencies per requirements
- v. Date notice was sent to resident representative
- vi. Date when staff reviewed the notice and its contents with the resident and resident representative
- vii. Date of formal discharge planning meeting and appeal rights
- viii. **Illinois** *The notice shall be on a form prescribed by the Department and shall contain all of the following:*
 1. *The stated reason for the proposed transfer or discharge; (Section 3-403(a) of the Act)*
 2. *The effective date of the proposed transfer or discharge; (Section 3-403(b) of the Act)*
 3. *A statement in not less than 12-point type, which reads: "You have a right to appeal the facility's decision to transfer or discharge you. If you think you should not have to leave this facility, you may file a request for a hearing with the Department of Public Health within 10 days after receiving this notice. If you request a hearing, it will be held not later than 10days after your request, and you generally will not be transferred or discharged during that time. If the decision following the hearing is not in your favor, you generally will not be transferred or discharged prior to the expiration of 30 days following receipt of the original notice of the transfer or discharge. A form to appeal the facility's decision and to request a hearing is attached. If you have any questions, call the*



Department of Public Health at the telephone number listed below."; (Section 3-403(c) of the Act)

4. *A hearing request form, together with a postage paid, preaddressed envelope to the Department; and (Section 3-403(d) of the Act)*
5. *The name, address, and telephone number of the person charged with the responsibility of supervising the transfer or discharge. (Section 3-403(e) of the Act)*

b. Documentation will include the basis for the transfer and the services to be provided by the receiving health care provider that will meet the resident's needs. A copy of the discharge transfer notice will be kept in the medical record. (Phase II – the specific needs that cannot be met, facility attempts to meet the residents needs and the services available at the receiving facility to meet the resident's needs. The resident's physician will document reason for discharge and that the discharge/transfer is necessary for the resident's well-being.)

c. Against Medical Advice

If a resident chooses to leave the facility against medical advice, include documentation of the following:

1. Capacity This term refers to the residents' medical ability to make a decision. Documenting that the resident "understood" offers little protection, while documenting the ability to carry on a conversation and demonstrate reason provides a much more compelling example of their capacity to make decisions.
2. Signs and Symptoms The resident and provider need to agree on both the individual's symptoms and also the providers concerns.
3. Extent of Care and Services Document what has been done as well as the limitations that still exist.
4. Current Plan of Care Document that you have reviewed their current plan of care and need for services, treatment, etc.
5. Risks of Foregoing Services Document discussion of potential risks
6. Alternatives and options Document if other options or alternatives were discussed and the individual's response

7. Explicit Statement of AMA and About What the Resident is Refusing Document a specific statement about AMA discharge and what the resident is specifically refusing.

8. Questions, Follow-up, Medicines, Instructions When patients leave AMA, providers should do whatever is possible to limit potential negative outcomes. All questions should be answered.

J. Orientation for transfer/discharge

- a. The facility will provide the resident with sufficient preparation and orientation to the upcoming discharge to ensure that the discharge is safe and orderly. The orientation will be provided to the resident and resident representative in a form and manner that can be understood.
- b. The resident will be provided with information about where he/she is going.
- c. The facility will work with the resident and family to ensure that valued possessions are not left behind
- d. The facility will coordinate with the financial departments to ensure the transition of resident funds to the appropriate entities. Funds will be transferred at the time of discharge
- e. The facility will orient the staff in the receiving facility about the care needs of the resident, the daily patterns and preferences
- f. The facility will minimize unnecessary and avoidable anxiety or depression for the discharging resident.
- g. The facility will provide the appropriate education related to medication, treatments, medical care and services, psychosocial needs, care interventions and approaches and other applicable approaches for a safe care transition

K. Information for the receiving provider

- a. The facility will share relevant information with the post-discharge care provider, including:
 - i. The resident's primary care physician and other consulting practitioners as well as their respective and contact information
 - ii. The resident representative's contact information
 - iii. The resident's Advance Directives
 - iv. All special instructions or precautions and for ongoing care as appropriate
 - v. The resident's comprehensive care plan goals
 - vi. A copy of the discharge summary



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- vii. Any other necessary or relevant information or documentations to facilitate safe and effective transition of care
- viii. **(Insert facility and state specific requirements here)**

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References

Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities
10/04/16:

<https://www.federalregister.gov/documents/2016/10/04/2016-23503/medicare-and-medicaid-programs-reform-of-requirements-for-long-term-care-facilities>

CMS Memo Ref: S&C 17-07-NH: Advance Copy – Revisions to State Operations Manual (SOM),
Appendix PP- Revised Regulations and Tags, 11/09/16:

<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-07.pdf>

The Proper Way to Go Against Medical Advice

<https://www.aliem.com/2014/proper-way-to-go-against-medical-advice/>

*(Illinois) Joint Committee on Administrative Rules Administrative Code Title 77: Public Health, Chapter 1:
Department of Public Health, Subchapter c: Long-Term Care Facility*

<http://www.ilga.gov/commission/jcar/admincode/077/077003000C06260R.html>

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