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www.elderjusticeny.org

Nursing Home (Rehabilitation Facility)[1]: Involuntary Transfer/Discharge

On September 28, 2016 the Centers for Medicare & Medicaid Services (CMS) revised the federal nursing home regulations for the first time in 25 years. Any nursing home who accepts Medicare and/or Medicaid funding is required to abide by the federal regulations (in addition to state law). Included in the revisions are new requirements and protections for residents pertaining to involuntary transfer or discharge from a nursing home.

Federal and state laws and regulations apply to all residents who receive care in a nursing home: short-term care for rehabilitation services or long term care.

There are 6 times it is permissible for a nursing home to involuntarily discharge/transfer a resident[2]:

1. The discharge/transfer is necessary for the resident's welfare and the resident's needs cannot be met at the facility;

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

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

4. The health of individuals in the facility would otherwise be endangered;

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

    a. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay.
    b. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid.
    c. 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; or

[1] In NY there are no Medicare only certified facilities. As such every nursing home that is Medicare certified is also Medicaid certified; meaning each facility shall provide both short-term (rehabilitation services) and long-term care.
[2] See 42 CFR 483.15(c)(1)(i) and 10 NYCRR 415.3(h)(1).

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6. The facility ceases to operate.

If the notice does not list any of the 6 reasons it is invalid.

The general rule is written notice must be provided at 30 days before the resident is discharged/transferred. However 30 day written notice is not required when[3]:

1. The safety of other individuals in the facility would be endangered;
2. The health of other individuals in the facility would be endangered;
3. The resident's health has improved sufficiently to allow for a more immediate discharge/transfer;
4. The discharge/transfer is due to the resident's urgent medical needs; or
5. The resident has not resided in the facility for 30 days.

In the above situations written notice may be given as "soon as practicable" but not later than the day the facility made the decision to transfer/discharge the resident. This means the nursing home cannot provide you with written notice as you are being escorted out of the facility!

The facility must give notice to the resident and the resident's representative (if any) of the transfer/discharge and the reasons for the move in writing and in a language and manner they understand.[4]

Content of Notice[5]

Nursing homes are required to provide written notice of the discharge/transfer to the resident and must include the below components. If the notice is missing any such component, it is invalid.

Required components of written notice are as follows:

1. Reason for the discharge/transfer;
2. Specific regulations that support the transfer/discharge, or the change in Federal/State Law that requires the action;

[3] 42 CFR 483.15(c)(4) ; 10 NYCRR 415.3(h)(1)(iv)
[4] 42 CFR 483.15(c)(3); 10 NYCRR 415.3(h)(1)(iii)
[5] See 42 CFR 483.15 (c)(5) and 10 NYCRR 415.3(h)(1)(v)

3. Effective date for the discharge/transfer;

4. Location to where resident is being transferred/discharged;

5. Statement the resident has the right to appeal to New York State Department of Health [6]; and

6. Name, address, and phone number of the State Long Term Care Ombudsman.

Required Documentation[7]

Nursing homes are required to ensure the discharge/transfer is documented in the resident's record which includes:

1. The basis of the transfer;

2. The documentation must be done by the resident's physician when the basis is due to the resident's health has improved sufficiently so that the resident no longer needs nursing home level of care.

3. If the basis is due to the resident's need(s) cannot be met at the facility, the documentation must be done by the resident's physician and must include:
   a. The specific resident need(s) that cannot be met;
   b. How the facility attempted to meet the resident need(s); and
   c. The service available at the receiving facility to meet the need(s).

4. The documentation must be done by a physician if the basis is due to safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident, or the health of individuals in the facility would otherwise be endangered.

5. Ensure appropriate information is communicated to the receiving health care institution or provider which must at the minimum include:
   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; and
   f. All other necessary information, including a copy of the residents discharge summary to ensure a safe and effective transition of care.

[6] 10 NYCRR 415.3(h)(1)(v)(e) requires that the statement regarding the right to appeal to NYS DOH include specific language.
[7] 42 CFR 483.15(c)(2); 10 NYCRR 415.3(h)(1)(ii)

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Sufficient Orientation/Discharge Plan[8]

Nursing homes are required to provide and document that sufficient orientation and preparation for the resident to ensure a safe and orderly discharge/transfer from the facility. This orientation must be provided in a form and manner that the resident can understand. This includes enabling the resident, their legal representative or health care agent the opportunity in deciding where the resident will reside after discharge from the facility.

Frequent Questions and Answers

Q: Can the facility discharge/transfer a resident because the resident is being reclassified as "long-term" from "short-term/rehab"?

A: No. In in New York State, if a nursing home is Medicare licensed, every bed is a Medicare bed. Every nursing home is required to provide both short-term (usually for rehabilitation) and long-term care. This means a facility cannot discriminate against someone needing long-term care; whether it is someone who enters the nursing home as a new resident for short-term care or a short-term resident transitioning to long-term care.

*Resident room to room transfers within the nursing home are not subject to Nursing Home Transfer/Discharge rules.

Q: Can the facility discharge/transfer a resident during an appeal?

A: No. The new federal regulation states that a facility may not transfer or discharge a resident while the appeal is pending. However, if the failure to discharge or transfer would endanger the health or safety of the resident or others in the facility, the resident may be discharged/transferred during the appeal. In that situation the facility must document the danger the failure to transfer/discharge would pose.[9]

Q: What is involved in an appeal?

A: The resident has the right to an evidentiary hearing to appeal the proposed discharge/transfer. The resident can choose to retain an attorney. (An attorney <u>will not</u> be appointed.)

Request an appeal by calling the New York State Department of Health (NYS DOH) (1-888-201-4563) (or the phone # listed on the discharge notice).

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[8] 42 CFR 483.15(c)(7); 42 CFR 483.21(c); 10 NY CRR 415.3(h)(1)(vi) and (vii)
[9] 42 CFR 483.15(c)(1)(ii)

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The NYS DOH will request a copy of the notice from the facility to review it for validity. If the notice is not valid, the facility cannot discharge the resident. The facility will need to issue a new discharge/transfer notice, and the resident can file another appeal. The NYS DOH Bureau of Adjudication is the entity that conducts the hearing and will set the date/time/place of the hearing. Typically the hearing is at the facility where the resident resides. The facility has the burden to prove the discharge/transfer is necessary and the discharge plan is appropriate.

Q: What happens if a resident goes to the hospital (acute-care facility)?

A: The resident's return to the nursing home from an emergent transfer to a hospital is generally expected. However, if the nursing home chooses to discharge a resident who is in the hospital, the nursing home is required to fully evaluate the resident and not base the discharge on the resident's status at the time of the transfer to the hospital.

Q: Can a nursing home discharge a resident who is 'difficult' to care for?

A: No. A resident who is classified by the facility as 'difficult' (i.e. the resident is argumentative, does not follow facility policies, refuses treatment, or is disruptive), is not a basis for discharge. In addition, a facility cannot discharge a resident who needs more supervision, higher needs, or is more expensive to care for than other residents. It is the nursing home's responsibility to properly assess every potential resident and only admit those they can properly care for.

Q: What about bed holds?

A: Nursing homes are required to issue two notices related to the facility's bed hold policies. The first notice should be given well in advance of any transfer (typically in the admissions paperwork-must be reissued if state law or facility policy changes); the second notice, which is required to specify the duration of the bed hold policy, should be given to the resident (or representative) at the time of transfer.

Q: The Center for Elder Law & Justice (CELJ) has a Health Care Advocacy Unit, can they help?

A: Yes. CELJ's Health Care Advocacy Unit may be able represent the resident in his/her appeal of the discharge/transfer notice. If a resident has been issued written (or verbal) notice, call CELJ's Health Care Advocacy Unit for assistance: (716) 853-3087 x 223.

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