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LeadingAge PA and PADONA Webinar
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ROPs: Resident Behavior and Facility Practices: Looking at Admission, Transfer & Discharge

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Overview

- New regulations place an increased focused on admission, transfer and discharge requirements
- Residents and their representatives have greater rights and protections
- Proactive steps you can take now and in the future using the State Operations Manual (SOM) and critical element pathways (CEPs)

Preadmission Screening and Resident Review (PASARR) CEP: Critical Elements Decisions

1. Is there evidence of Level I pre-screening of the resident to determine if the newly admitted resident had or may have had a serious mental illness, intellectual or developmental disability or a related condition prior to admission?
2. If pre-admission screening of residents expected to be in the facility 30 days or less is not performed, and the presumed short-stay resident was not screened prior to admission to the facility and remained in the facility longer than 30 days, did the facility screen the resident?
3. If the Level I pre-screening identified that the resident had or may have had an MD, ID or related condition, did facility refer the resident to the appropriate state-designated authority for Level II PASARR evaluation and determination?

PASARR CEP: Critical Elements Decisions

4. For a resident who had a negative Level I pre-screen, who was later identified with newly evident or possible serious MD, ID or a related condition, did the facility refer the resident to the appropriate state-designated authority for Level II PASARR?
5. For a resident with a Level II, did facility coordinate assessments with the PASARR program by incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into the resident's assessment, care planning, and transitions of care?
6. If resident's significant change in status was related to newly evident or possible MD, ID or related condition, did facility notify appropriate state-designated mental health or ID authority for a Level II evaluation as soon as the criteria indicative of a significant change in status was evident?

PASARR CEP: Critical Elements Decisions

7. Did facility notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has a mental disorder or intellectual disability for a review?

8. For the newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a *baseline care plan within 48 hours* of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative *receive a written summary* of the baseline care plan that he/she was able to understand?

PASARR CEP: Critical Elements Decisions

9. If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental, and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition?
10. If there was a significant change in the resident's status, did the facility complete a significant change in status assessment within 14 days of determining the status change was significant?
11. Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths and areas of decline, accurately complete the resident assessment?

PASARR CEP: Critical Elements Decisions

12. Did the facility develop and implement a comprehensive person-centered care plan that includes measureable objectives and timeframes to meet the resident's medical, nursing, mental, and psychosocial needs and includes the resident's goals, desired outcomes, and preferences?
13. Did the facility reassess the effectiveness of the interventions and review and revise the resident's care plan (with input from the resident), if necessary, to meet the resident's needs?

Admissions Considerations

- Facilities are required to determine their capacity and capability to care for the residents they admit
  - Do not admit residents whose needs you cannot meet based on the Facility Assessment (See F838, Facility Assessment)
  - There may be rare situations, such as when a crime has occurred, that a facility initiates a discharge immediately, with no expectation of the resident's return.

Resident's Right to Return

- In reviewing complaints for facility-initiated discharges that do not honor a resident's right to return following a hospitalization or therapeutic leave, surveyors will review both transfer and discharge requirements because the situation begins as a transfer and then changes to a discharge when the facility decides it will not permit the resident to return

Assess and Document Non-Emergent Transfer for Sig Change

- If transfer is due to a significant change in the resident's condition, but not an emergency requiring an immediate transfer, then *prior to any action*, the facility must conduct and document the appropriate assessment to determine if revisions to the care plan would allow the facility to meet the resident's needs

(See §483.20(b) (2) (ii), F637 for information concerning assessment upon significant change)

Refusal of Treatment

- Resident's declination of treatment does not constitute grounds for discharge, unless the facility is unable to meet the needs of the resident or protect the health and safety of others
- Must be able to demonstrate that the resident or, if applicable, resident representative, received *information regarding the risks of refusal* of treatment
- Staff must conduct the appropriate assessment to determine if care plan revisions would allow the facility to meet the resident needs or protect the health and safety of others

Behavior Issues

- A facility may have concerns about permitting a resident to return to the facility after a hospital stay due to the resident's clinical or behavioral condition at the time of transfer. *The facility must not evaluate the resident based on his or condition when originally transferred to the hospital*. If the facility determines it will not be permitting the resident to return, the medical record should show evidence that the facility made efforts to:
  - Determine if the resident still requires the services of the facility and is eligible for Medicare skilled nursing facility or Medicaid nursing facility services.

Behavior Issues

- Ascertain an accurate status of the resident's condition — this can be accomplished via communication between hospital and nursing home staff and/or through visits by nursing home staff to the hospital.
- Find out what treatments, medications and services the hospital provided to improve the resident's condition. If the facility is unable to provide the same treatments, medications, and services, the facility may not be able to meet the resident's needs and may consider initiating a discharge. For example, a resident who has required IV medication or frequent blood monitoring while in the hospital and the nursing home is unable to provide this same level of care.

Behavior Issues

- Work with the hospital to ensure the resident's condition and needs are within the nursing home's scope of care, based on its facility assessment, prior to hospital discharge. For example, the nursing home could ask the hospital to:
  - Attempt reducing a resident's psychotropic medication prior to discharge and monitor symptoms so that the nursing home can determine whether it will be able to meet the resident's needs upon return;
  - Convert IV medications to oral medications and ensure that the oral medications adequately address the resident's needs.

Behavior Issues

- To cite deficient practice at F626, the surveyor's investigation will generally show that the facility failed to:
  - Establish and/or implement a policy that is in accordance with the State Medicaid plan, and addresses returning to the facility following hospitalization or therapeutic leave; or
  - Ensure that residents whose hospitalization or therapeutic leave exceeds the State's bed-hold period are returned to their previous room and/or the first available bed in a semi-private room; or

Behavior Issues

- Ensure (for a resident not permitted to return) the medical record and notification contain a valid basis for discharge; or
- Permit a resident to return to the same composite distinct part in which they previously resided.

Discharge Pending Appeal

- If resident appeals discharge facility may not discharge the resident while the appeal is pending unless necessary to protect health and safety

- If a resident's initial Medicaid application is denied but appealed, the resident is not considered to be in nonpayment status

Therapeutic Leave and Discharge

- Therapeutic leave is a resident-initiated transfer
- If the facility makes a determination to not allow the resident to return, the transfer becomes a facility-initiated discharge

Therapeutic Leave and Discharge

- Facilities must not treat situations where a resident goes on therapeutic leave and returns later than agreed upon, as a resident-initiated discharge
- Resident must be permitted to return and be appropriately assessed for any ill-effects from being away from the facility longer than expected, and provide any needed medications or treatments which were not administered because they were out of the building

Therapeutic Leave and Discharge

- If a resident has not returned from therapeutic leave as expected, the medical record should show evidence that the facility attempted to contact the resident and resident representative
- Must not initiate a discharge unless it has ascertained from the resident or resident representative that the resident does not wish to return

Orientation For Transfer Or Discharge

- Must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility
- Orientation must be provided in a form and manner that the resident can understand
- Sufficient preparation and orientation means the facility informs the resident where he or she is going, and takes steps under its control to minimize anxiety

Bed Holds

- Must have policies that address holding a resident's bed during periods of absence, such as during hospitalization or therapeutic leave
- Must provide written information about these policies to all residents *prior to* ***and*** *upon transfer* for such absences
- Must issue two notices related to bed-hold policies

Bed Holds

- First notice can be given well in advance of any transfer, i.e., information provided in the admission packet
- Second notice must be provided to the resident, and if applicable the resident's representative, *at the time of transfer, or in cases of emergency transfer, within 24 hours*
- "It is expected that facilities will document multiple attempts to reach the resident's representative in cases where the facility was unable to notify the representative"

Bed Holds

- Facilities must permit residents to return to the facility immediately to the first available bed in a semi-private room
- Bed-hold for days of absence in excess of the State's bed-hold limit is considered a noncovered service which means that the resident could use his/her own income to pay for the bed-hold
- If resident does not elect to pay to hold the bed, the resident must be permitted to return to the next available bed

Notice of Transfer or Discharge

Type of Transfer/Discharge	Timing of Notice
Resident Initiated	No notice needed
Emergency Transfer	• As soon as practicable to resident and/or representative • Monthly to State Ombudsman
Facility Initiated: Resident in Hospital	• Immediately or as soon as possible to resident and/or representative • Same time to State Ombudsman
Facility Initiated: Other Reasons (non-payment; resident/others safety; can't meet needs; doesn't need care)	• At least 30 days prior to discharge to resident and/or representative • Same time to State Ombudsman

Content of Discharge Notice

- Reason for transfer or discharge
- Effective date
- Location to which resident is to be sent
- Explanation of right to appeal to the State
- PA Bureau of Hearings & Appeals address (mail and email), and telephone number
- Information on how to request an appeal hearing

Content of Discharge Notice

- Information on obtaining assistance in completing and submitting the appeal hearing request
- Name, address, and phone number of the representative of the Office of the State Long-Term Care ombudsman
- For residents with MD and ID/DD, notice must include the name, mail and e-mail addresses and phone number of the state protection and advocacy agency

Information Conveyed to Receiving Provider

- Contact information of the attending practitioner
- Resident representative contact information
- Advance directive information
- Special instructions and/or precautions for ongoing care, as appropriate, which must include, if applicable, but are not limited to:
  - Treatments and devices (oxygen, implants, IVs, tubes/catheters)
  - Precautions such as isolation or contact
  - Special risks such as risk for falls, elopement, bleeding, or pressure injury and/or aspiration precautions

Information Conveyed to Receiving Provider

- All information necessary to meet the resident's needs, which includes, but may not be limited to:
  - Resident status, including baseline and current mental, behavioral, and functional status, reason for transfer, recent vital signs
  - Diagnoses and allergies
  - Medications (including when last received); and
  - Most recent relevant labs, other diagnostic tests, and recent immunizations
- Additional information, if any, outlined in the transfer agreement with the acute care provider

Hospitalization CEP: Critical Element Decisions

1. Did the facility ensure that the resident received treatment and care to prevent the hospitalization, that was in accordance with professional standards of practice, their comprehensive, person-centered care plan, and the resident's choice?
   - If no: cite Quality of Life, Quality of Care or F684

Hospitalization CEP: Critical Element Decisions

2. Was the basis for the resident's transfer/discharge consistent with the regulations?
   - Does evidence in the medical record support the basis for transfer/discharge and meet the documentation requirements?
   - Is there evidence that the information conveyed to the receiving provider met the requirements?
   - Was a resident who appealed their discharge permitted to return to the nursing home while their appeal was pending, unless there was evidence that the resident's return would pose a health or safety risk to individuals in the facility, or there was no bed?
   - If no: cite F622

Hospitalization CEP: Critical Element Decisions

3. Did the facility notify the resident and resident's representative in writing of the reason for the transfer/discharge to the hospital in a language they understand and send a copy of the notice to the ombudsman?

   AND/OR

   For residents who were not permitted to return following hospitalization (who were discharged), did the facility also provide a notice of discharge to the resident, resident representative and send a copy of the notice to the representative of the Office of the Long-Term Care Ombudsman?

   - If No, cite F623

Hospitalization CEP: Critical Element Decisions

4. Was the resident sufficiently prepared and oriented for their transfer to the hospital?
   - If No, cite F624
5. Did the facility notify the resident and/or resident's representative of the facility policy for bed hold, including reserve bed payment?
   - If No, cite F625

Hospitalization CEP: Critical Element Decisions

6. Was the resident allowed to return to the facility, to the first available bed, or to their previous room if available, after being hospitalized?
   - If No, cite F626

Discharge CEP: Critical Element Decisions

1. Did the facility:
   - Involve the IDT, resident and/or resident representative in developing a discharge plan that reflects the resident's current discharge needs, goals, and treatment preferences while considering caregiver support
   - Document that the resident was asked about their interest in receiving information about returning to the community
   - Assist the resident and/or resident representatives in selecting a post-acute care provider if the resident went to another skilled nursing facility, nursing home, home health agency, inpatient rehab facility, or LTC hospital

- If No, cite F660

Discharge CEP: Critical Element Decisions

2. Did the facility:
   - Develop a discharge summary which includes a recapitulation of the resident's stay, a final summary of the resident's status, and reconciliation of all pre- and post-discharge medications?
   - Develop a post-discharge plan of care, including discharge instructions?

- If No, cite F661

Discharge CEP: Critical Element Decisions

3. Does the resident's discharge meet the requirements at 483.15(c)(1) (i.e., for the resident's welfare, the resident's needs could not be met in the facility, the resident no longer required services provided by the facility, the health or safety of the individuals in the facility was endangered, non-payment, or the facility no longer operates)?
   - If No, cite F622

Discharge CEP: Critical Element Decisions

4. Was required discharge information documented in the resident's record and communicated to the receiving facility?
   - If No, cite F622
5. If this was a facility-initiated discharge, was resident and resident representative notified of discharge in writing and in a manner they understood at least 30 days in advance of the discharge? Did the notice meet all requirements?
   - If No, cite F623

Discharge CEP: Resident Family Interviews

- What are your discharge plans?
- What has the facility discussed with you about returning to the community or transitioning to another care setting?
- Were you asked about your interest in receiving information regarding returning to the community? If not, are you interested in receiving information?
- What was your involvement in the development of your discharge plan?

Discharge CEP: Resident Family Interviews

- What has the facility talked to you about regarding post-discharge care?
- Ask about any discrepancies between the resident's discharge plan and the facility's discharge plan.
- If discharge is planned:
  - How did the facility involve you in selecting the new location?
  - Did you have a trial visit, if feasible? How did it go?

Discharge CEP: Resident Family Interviews

- How were your goals, choices, and treatment preferences taken into consideration?
- What are your plans for post-discharge care (e.g., self-care, caregiver assistance)?

Discharge CEP: Resident Family Interviews

- What information did the facility give you regarding your discharge (e.g., notice, final discharge plan)?
  - When was it given?
  - Was the information understandable; and
  - What discharge instructions (e.g., medications, rehab, durable medical equipment needs, labs, contact info for home health, wound treatments) has the facility discussed with you?

Discharge CEP: Resident Family Interviews

- Were you given a copy of the discharge instructions?
- If applicable, did the facility have you demonstrate how to perform a specific procedure so that you can do it at home?

Discharge CEP: Staff Interviews (Including Attending Practitioner)

- What is the process for determining whether a resident can be discharged back to the community?
- How do you involve the resident or resident representative in the discharge planning?
- Do you make referrals to the Local Contact Agency when the resident expresses an interest in being discharged?
- How often are the discharge needs of the resident evaluated and is the post-discharge plan of care updated?

Discharge CEP: Staff Interviews

- What is the resident's discharge plan, including post-discharge care?
- Why is the resident being discharged (i.e., for the resident's welfare and the resident's needs cannot be met in the facility, because the resident no longer required services provided by the facility, because the health or safety of the individual was endangered, or due to nonpayment)?

Discharge CEP: Staff Interviews

- For residents being discharged to another healthcare provider:
  - What did the facility do to try and provide necessary care and services to meet the resident's needs prior to discharge?
  - What does the new facility offer that can meet the resident's needs that you could not offer?
  - Where is the resident being discharged to?
  - How was the resident involved in selecting the new location?
  - Was a trial visit feasible?

Discharge CEP: Staff Interviews

- What, when and how is a resident's discharge summary, and other necessary healthcare information shared with staff at a new location?
- For discharge summary concerns are noted, interview staff responsible for the discharge summary.
  - How does the facility provide education to the resident or care provider regarding care and treatments that will be needed post discharge?

Discharge CEP: Record Review

- If the resident cannot return to the community, who made the determination and why?
- Did the facility identify the resident's discharge needs and regularly re-evaluate those discharge needs?
- Does the care plan adequately address the resident's discharge planning? Does it address identified needs, measureable goals, resident and/or resident representative involvement, treatment preferences, education, and post-discharge care?

Discharge CEP: Record Review

- Has the care plan been revised to reflect any changes in discharge planning?
- Who from the IDT was involved in the ongoing process of developing the discharge plan?
- What are the circumstances and basis for the discharge? Was the discharge necessary? Was the reason for the discharge documented by a physician, as appropriate?

Discharge CEP: Record Review

- Is there documentation of the specific needs that could not be met, the attempts the facility made to meet the resident's needs, and the specific services the new facility will provide to meet the resident's needs?

Discharge CEP: Record Review

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Discharge CEP: Record Review

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Discharge CEP: Record Review

- If the resident went to a SNF, HHA, IRF, or LTCH, did the facility assist the resident and the resident representative in selecting a post acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH available standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available that is relevant and applicable to the resident's goals of care and treatment preferences.

Discharge CEP: Record Review Facility-Initiated Discharges

- Was advance notice given (either 30 days or, as soon as practicable, depending on discharge reason) to the resident, resident representative, and a copy to the ombudsman:
  - Did the notice include all the required components (reason, effective date, location, appeal rights, Ombudsman, ID and MI info as needed) and was it presented in a manner that could be understood; and
  - If changes were made to the notice, were recipients of the notice updated?

Discharge CEP: Record Review Facility-Initiated Discharges

- Did the facility provide a discharge summary to the receiving provider, which includes all required components at F661?
- Does the discharge summary include a recapitulation of the resident's stay, a final summary of the resident's status, and reconciliation of all pre- and post-discharge medications? If not, describe what is missing.

Discharge CEP: Record Review Facility-Initiated Discharges

- For residents discharged to the community, does the medical record have evidence that written discharge instructions were given to the resident and if applicable the resident representative?

Hospice and End of Life Care and Services CEP: Critical Element Decisions

1. A. Did facility provide appropriate treatment and services for end of life care?

   B. For a resident receiving hospice services: Did facility collaborate with the hospice for the development, implementation, and revision of the coordinated plan of care and/or communicate and collaborate with the hospice regarding changes in the resident's condition, *including transfer to the emergency department and/or hospital, if applicable*?

Hospice CEP: Critical Element Decisions

2. Did facility have an agreement to provide hospice services, designate staff to the facility's interdisciplinary team who works with the hospice representative to coordinate care, and ensure each resident's care plan includes a description of the care and services provided by the hospice and facility?

Immediate Jeopardy Examples

- Facility failed to allow a resident to return following a hospitalization
  - The medical record did not accurately evaluate the resident, rather they used the resident's status prior to the transfer as the basis for discharge
- Facility failed to allow a resident to return following therapeutic leave to a family member's home, resulting in the resident being found living on the street, without food or shelter. The medical record did not contain evidence of a valid basis for discharge, and there was no evidence of discharge planning.

Actual Harm Example

- Facility failed to allow a resident to return following a hospitalization that exceeded the bed-hold policy (and state plan) and discharged resident on the basis of being unable to meet his needs
- The survey team verified that facility had accepted residents with similar conditions during the timeframe that resident was ready to return
- Resident sent to another facility which was in a location not easily accessible by the resident's family. The resident expressed feelings of depression and loneliness

Questions

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