How to Legally & Appropriately Discharge or Transfer Residents of LTC Facilities in Wisconsin

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Issue

How do you legally and appropriately "Transfer" or "Discharge" an LTC resident and avoid claims of illegal "dumping"?
Objectives of Presentation

Review Relevant Wisconsin & Federal Regulations for:

- Chapter DHS 132 Nursing Homes
- Chapter DHS 83 CBRF's
- Chapter DHS 89 RCAC's
- Facilities Participating in Medicare & Medicaid Programs

Discuss How These Rules Work in Challenging Scenarios

Provide Suggestions & Best Practices From Legal & Facility Management Perspectives
Nursing Homes
DHS 132.53 (1) & (2) - Transfers and Discharges

No resident may be **discharged** or **transferred** from a nursing home unless:

- There is a "request" or "informed consent" of resident or guardian to do so;
- Nonpayment of charges, following a reasonable opportunity to pay;
- Care requirements beyond the facility's license;
- Care requirements facility does not provide and is not required to provide;
- Medical reasons ordered by physician;
- Medical emergency or disaster;
- Health, safety or welfare of resident or other residents is endangered and **documented**;
- Resident does not need nursing home care;
- Short-term care period expires;
- As otherwise permitted by law.
DHS 132.53 (2)(b) - Alternate Placement Requirement

Except for situations involving non-payment or medical emergencies, no resident may be transferred or discharged from a nursing home unless:

- "alternative placement" is arranged,

- a "reasonable advanced notice" is provided with explanation of need for transfer and alternatives, and

- receiving facility has agreed to "accept" resident in advance
DHS 132.53 (3)(a) – 30 Day Notice Requirement

At least 30 days prior to transfer or discharge a nursing home must provide a written notice that meets the following requirements:

- Must be sent to resident, resident's physician and, if known, immediate family or legal counsel, guardian or other responsible person;
- Must state reasons for transfer or discharge;
- Must provide name, address and phone number of Board on Aging and LTC Program;
- For residents with developmental disability or mental illness, must provide contact information for a designated mental health advocacy agency under Wis. Stat. §51.62 (2)(a);

Exception to 30-day notice requirement: "... the continued presence of resident endangers health, safety or welfare of the resident or others."
A "planning conference" shall be held at least 14 days before transfer or discharge.

- Attendees must include: resident, guardian, if any, and any appropriate county agency or others designated by resident;
- Must review need for relocation, effect on resident, alternatives and relocation plan.

**Exception:** Resident is receiving respite care or circumstances pose "danger to health, safety or welfare of resident".
DHS 132.53(3)(b) 3 & 4 – Relocation Plan

A "relocation plan" must be developed that includes the following activities:

• Counseling regarding transfer;
• Opportunity to visit new facility and meet staff;
• Assistance with moving;
• Need for medication and treatment during move.

Resident must be advised of "assistance required" and "shall be provided with that assistance upon request."

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DHS 132.53 (3)(c) – Record Transfer

At time of discharge or transfer nursing home facility must prepare and provide a discharge "summary" with the following information:

• Current medical findings and condition;
• Final diagnosis;
• Rehabilitation potential;
• Summary and course of treatment;
• Nursing and dietary information;
• Ambulation status;
• Administrative and social information;
• Needed continued care and instructions.

Facility must also prepare a "funds and property statement" accounting for all funds and property held at facility for resident.
DHS 132.53 (4) – Transfer Agreements

Each nursing home facility shall have in effect a "transfer agreement" with one or more hospitals for inpatient or other hospital services.

Intermediate care facilities shall have in effect a Transfer Agreement with one or more skilled nursing facilities.

Transfer Agreements must ensure:

• Prompt and timely availability;
• Interchange of medical and other necessary information.
**Emergency Transfer In:** In an emergency, a resident may be confined in a locked unit if necessary to protect the resident or others from injury provided the facility immediately attempts to notify the physician for instructions. A physician's order for the confinement must be obtained within 12 hours. No resident may be confined for more than an additional 72 hours under order of the physician.

**Transfer Out:** A facility may transfer a resident from a locked unit to an unlocked unit without court approval pursuant to s. 55.15, Stats., if it determines that the needs of the resident can be met on an unlocked unit. Notice of the transfer shall be provided as required under s. 55.15, Stats., and shall be documented in the resident's medical record.
Prior to any transfer of a resident between rooms or beds within a facility, the resident or guardian, if any, and any other person designated by the resident shall be given reasonable notice and an explanation of the reasons for transfer. Transfer of a resident between rooms or beds within a facility may be made only for medical reasons or for the resident's welfare or the welfare of other residents or as permitted under s. DHS 132.31 (1) (p) 1.
DHS 132.53 (5): A nursing home resident who is on leave or is temporarily discharged and has expressed an interest to return should not be denied readmission unless:

- Resident waives right to have bed held; or
- 15 days following temporary leave or discharge;
- Whichever is earlier.

483.12 (b): Before transferring a resident facility must provide written information that specifies:

- Duration of bedhold policy under State Plan (See DHS 132.53 (5)), and
- Describes the facility's bedhold policy which must allow:
  - Immediate return to nursing facility after a period of hospitalization or therapeutic leave lasting 15 days or more then the first bed becomes available.
Do You Have to Readmit Resident?

Is a resident's right to return to same bed automatic, or does there need to be a reexamination, reevaluation and readmission?

What happens if reevaluation reveals the resident falls outside the admission limitations under DHS 132.51? These clearly state:

- No person requiring care beyond license is to be retained;
- No resident whose condition changes to require care beyond license is to be retained;
- No resident whose behavior is abusive, violent, destructive, harassing or intimidating is to be retained "unless the facility has and uses sufficient resources to appropriately manage and care for them".
Federal Transfer and Discharge Regulations

Federal Rules in CFR sec. 483.12 apply to any Skilled Nursing Facility participating in the Medicare program and any nursing facility participating in the Medicaid program.

A facility must establish and maintain identical polices and practices regarding transfer and discharge regardless of source of payment.
The facility must permit each resident to remain in the facility, and not transfer or discharge the resident unless:

- It is necessary for resident's welfare, needs can't be met in facility
- It is appropriate because the resident's health has improved and no longer needs services provided by facility
- Safety of individuals in facility is endangered
- Health of individuals in facility is endangered
- Resident has failed, after reasonable and appropriate notice, to pay for stay at facility
- Facility ceases to operate
CFR 483.12 (a)(3) Documentation Requirement

Document! Document! Document!
CFR 483.12 (3) Documentation Requirement

When a facility transfers or discharges for any reason, "the resident's clinical record must be documented".

Documentation must be made by:

- **Resident's physician** if because health needs can't be met at facility, or resident no longer needs services provided by facility; or
- **A physician** if health of individuals in facility would be endangered
CFR 483.12 (4) Notice Requirement

A notice of transfer or discharge must be sent 30 days before At least 30 days before a transfer or discharge, a facility must notify the resident and, if known, a family member or legal representative "in a language and manner they understand" of the following information:

- Reason for transfer or discharge
- Date of transfer or discharge
- Location to which resident will be taken
- Statement that resident may appeal decision to State of Wisconsin, DHS
- Name, address and telephone number of state long-term care ombudsman
- If the resident is developmentally disabled, provide the mailing address and telephone number of the agency responsible for the protecting and advocating for disabled citizens.
In situations where a transfer or a discharge occurs in less than 30 days, a notice is to be sent "as soon as practicable."
A facility must provide sufficient preparation and orientation to residents going to a new facility to ensure safe and orderly transfer or discharge.
Nursing Homes – Case Study

An 80 year old male with moderate Alzheimer's moves into a Skilled Nursing Facility from a CBRF due to a fall resulting in a hip fracture. Upon arrival he is noted to be forgetful, moody and withdrawn. He is confused about where he is at, time of day and needs help choosing proper clothing. He also has trouble controlling his bladder and bowel and has difficulty sleeping. He is suspicious of others, delusional, compulsive and engages in repetitive behavior such as hand ringing or tissue shredding.

The Skilled Nursing Facility does not have a memory care unit and has found the resident to be very challenging. As his hip fracture heals, he is becoming more mobile but also is beginning to verbally and physically abuse other residents and is combative with staff. He is also beginning to demonstrate "exit seeking behaviors" and the staff believes he is no longer capable of being safely cared for in that facility.

The facility managers have met with the resident and his immediate family to discuss a transfer to another facility which has memory care services. The family denies this is necessary and believes moving the resident will have a negative impact on his health.

From both a legal and clinical perspective, what should the managers of this facility do?
Community Based Residential Facilities

CBRF
A CBRF may temporarily transfer a resident if a "condition or actions of resident" requires an emergency transfer to a hospital, nursing home or other facility for treatment not available from CBRF.
DHS 83.31 (3) & (4) – Transfer or Discharge

No resident may be discharged or transferred from a CBRF except for the following reasons or circumstances:

- Resident initiates transfer or discharge pursuant to Admission Agreement;
- Non-payment of charges, following reasonable opportunity to pay;
- Care required is beyond CBRF's license classification;
- Care required is inconsistent with CBRF's program statement and beyond that which CBRF is required to provide under terms of admission agreement and this chapter;
- Medical care is required that CBRF cannot provide;
- There is imminent risk of serious harm to the health or safety of the resident, other residents or employees as documented in the resident's record;
- DHS decides to remove a resident because of licensing or operational issues; and
- As otherwise permitted by law.
At least 30 days before a CBRF involuntarily discharges a resident, it must provide a written notice to the resident or legal representative which contains the following:

- Reason and justification for discharge;
- Statement explaining resident has 10 days to request a DHS review of discharge decision (must provide name, address and telephone number of DHS regional office director);
- Name, address and phone number of Board of Aging and LTC for advocacy, if requested.
DHS 83.31 (4) (e) – Coercion and Retaliation Prohibited

Any form of coercion to discourage or prevent resident from requesting a DHS review is prohibited.
DHS 83.31 (5) & (6) – Return of Property and Funds

Personal Property – A resident has 30 days after discharge to remove personal property and belongings. After that, a CBRF may dispose of it;

Refunds – A CBRF shall return all refunds due to a resident within 30 days discharge;

Funds – A CBRF shall return all resident funds held within 14 days of discharge.
At time of transfer or discharge, CBRF shall inform resident, resident's legal representative and new place of residence that the following information is available in writing upon request:

• Facility Information – name, address, dates of admission, discharge and transfer date, and reason to contact for additional information;
• Names and addresses of resident's medical providers and dentists;
• Emergency contacts;
• Other "significant" contacts for resident;
• Assessment and individual service plan;
• Medical needs including current medications, dietary needs and physical and medical needs;
• Reason for discharge or transfer.
An 80-year-old male with early stage Alzheimer's Disease moves into a CBRF. At the time of arrival he is deemed to be competent, although he is noted to have mild memory issues, increased trouble with planning and organization and frequently loses or misplaces objects. Over the course of 24 months, his Alzheimer's progresses to middle stage and he is forgetful of events and his own personal history. In addition, he is beginning to feel moody, withdrawn and does not act well in social or mentally-challenging situations. He is frequently confused about where he is at, or what day it is and needs help choosing proper clothing for the season or occasion and also is having trouble controlling his bladder and bowel. The staff has noticed changes in his sleeping pattern and he is often seen sleeping during the day and becoming restless at night. It has also been noticed that he is wandering and becoming lost within the facility. There is no memory care unit within the CBRF, but also has a high resident-to-staff ratio.

CBRF staff and manager have determined the resident is now incompetent and should be discharged to a community that provides a higher level of memory care services. The resident and family deny the severity of the situation and believe that moving the resident will have a negative impact.

From both a legal and clinical perspective, what should you do?
Residential Care Apartment Complexes
DHS 89.29 (3) – Termination of Contract

An RCAC may terminate its contract with a tenant if any of the following conditions apply:

- Tenant's needs cannot be met at the level of services required to be available under DHS 89.23 (2);
- The time required to provide supportive, personnel and nursing services exceeds 28 hours per week;
- Tenant's condition requires the immediate availability of a nurse 24 hours a day;
- Tenant is adjudicated incompetent; has an activated Power of Attorney for Health Care; or has been found incapable of recognizing danger, summoning assistance, expressing need or making care decisions by healthcare providers;
- Tenant's behavior or condition poses an immediate threat to the health or safety of others (Note: mere old age, eccentricity or physical disability are insufficient);
- Tenant refuses to cooperate in examination by physician or licensed psychologist;
- Tenant's fees have not been paid, after being given a reasonable opportunity to pay deficiency;
- Tenant refuses to enter into a negotiated risk agreement or refuses to revise risk agreement based on a change in medical condition;
- Any condition develops and identified as grounds for termination in the service agreement.
An RCAC must provide 30 days advanced notice of termination to tenant and tenant's designated representative, if any. This notice shall include:

- The grounds for termination;
- Information about how to file a grievance consistent with the termination and grievance policies and procedures in the service agreement;

No 30 day notice is required in the event of an "emergency", meaning an immediate and documented threat to the health and safety of the tenant or others in the facility.
An RCAC may retain a tenant whose service needs can be met by the facility or can be met with services made available by another provider.

An RCAC may retain a tenant who becomes incompetent or incapable of recognizing danger, summoning assistance, expressing need or making care decisions provided that the facility ensures all of the following:

- Adequate oversight, protection and services are provided for the individual;
- The tenant has a guardian under ch. 54, Stats., or has an activated Power of Attorney for Health Care under ch. 155, Stats., or Durable Power of Attorney under ch. 244, Stats., or both;
- Both the Service Agreement and Risk Agreement are signed by the guardian and by the health care agent or the agent with power of attorney, if any.
RCAC – Case Study

An 80-year-old female tenant with early stage Alzheimer's moves into a RCAC. She has mild memory issues, increased trouble with planning and organizing and sometimes loses or misplaces objects. She is deemed competent at the time she moves in and does not require any nursing or care services.

Over the course of 24 months, her Alzheimer's progresses to a more advanced stage. She is now forgetful of events, including her own personal history. She is moody and withdrawn, especially in social or mentally-challenging situations. She is unable to recall information such as her own address, telephone number, or the high school or college she graduated from. She is confused as to the time of day and needs assistance choosing proper clothing. In addition, she has trouble controlling her bladder and bowel, is experiencing changes in her sleep pattern and confuses her days and nights and is also an increased risk of wandering and becoming lost within the facility.

The staff at the RCAC is becoming concerned about her behaviors and believes she is no longer competent of caring for herself within the 28 hours of nursing services available to an RCAC resident. The facility managers have met with the family to discuss the situation and have recommended a transfer to a higher level of care, perhaps a CBRF with a memory care unit. The family denies this is the situation and refuses to move the resident for fear of a negative impact on her.

From both a legal and clinical perspective, what should you do?
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