

Section 5

Admission, transfer, and discharge

SAMPLE

SAMPLE

Nondiscrimination

The facility admits residents without regard to race, color, creed, national origin, age, sex, religion, handicap, ancestry, marital or veteran status, sexual orientation, or payment source.

Policies and practices regarding transfer, discharge, and provision of services apply to all residents, regardless of payment source. Identical policies and practices means that facilities do not distinguish between residents based on their source of payment when providing services that are required to be provided under the law.

Admission policies

The facility's admission policies

- provide uniform guidelines for the admission of residents to the facility
- ensure that only residents who can be adequately cared for by the facility are admitted
- reduce the fears and anxieties of resident and family during the admission process
- are reviewed with the resident/representative (sponsor) (as are the facility's policies and procedures relating to resident rights, resident care, financial obligations, visiting hours, etc.)
- ensure that appropriate medical and financial records are provided to the facility prior to or upon the resident's admission

Equal access and opportunity for admission

All referral sources are ensured equal opportunity for admissions, and inquiries about the resident's race, religion, or ethnic background are prohibited.

The facility maintains a waiting list to ensure organized and equal access to the facility.

If the facility does not have an appropriate bed available at the time the referral is made, the resident's name is placed on a waiting list for future admission.

When a bed becomes available, the first person on the list who meets the admission criteria is offered the bed. The first person to accept the bed is admitted.

Admission criteria

Admission criteria are determined in advance of a referral to ensure that the facility is capable of managing the resident's illness (including behavior issues) and plan of care:

- Prospective admissions should be older than 18 years of age, unless a lower age is allowed by the state agency
- Prospective admissions should be free from active drug addiction, alcohol abuse, and communicable disease that cannot be managed and contained within the facility
- Prospective admissions may be ambulatory, bedridden, require post-operative care, or suffer from diabetes, cancer, neuromuscular disorders, or dementia
- Prospective admissions may be incontinent or require catheterization
- Prospective admissions may require the use of a feeding tube or require IV fluids, assuming that the facility is capable of providing these services

Medicare and Medicaid

The facility cannot require that residents or potential residents waive their rights to Medicare or Medicaid, nor can it require an oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits.

Medicaid recipients are considered for admission in compliance with applicable admission criteria and protocols of the state's Medicaid program.

In order for the facility to admit Medicaid participants,

- individuals should be at least 22 years of age and meet the nursing-facility services requirements. Alternatively, the state's medical review team can determine that individuals aged 21 or younger meet the admission criteria.
- the division or its agent must have determined that community care is either not available or not appropriate to meet the individual's needs.
- all preadmission screening requirements must be met.

Prohibited admission practices

The facility does not engage in the following practices, as they may be construed as being in conflict with Medicare and Medicaid rules and regulations:

- Make a direct request or requirement that the resident sign admissions documents explicitly promising or agreeing not to apply for Medicare or Medicaid
- Make an indirect request requiring the resident to pay private rates for a specified period, such as two years (private pay duration of stay contract) before Medicaid will be accepted as a payment source for the resident
- Require side agreements requiring the resident to be private pay or to supplement the Medicaid rate

- Seek nor receive any kind of assurances that the resident is not eligible, or will not apply, for Medicare or Medicaid benefits

Survey alert:

Surveyors will be alerted to trends that seem to indicate that the facility is transferring residents to hospitals at the time (or shortly before) their payment source changes from private-pay or Medicare to Medicaid.

Mental illness, mental retardation, and developmental disabilities

The Omnibus Budget Reconciliation Act of 1987 (OBRA 87) requires that individuals diagnosed with major mental illness, mental retardation, or developmental disabilities are screened prior to admission.

Charging for services

The facility may charge any amount for services furnished to non-Medicaid residents, provided that there is proper and timely notice describing the charges.

All nursing services, specialized rehabilitative services, social services, dietary services, pharmaceutical services, or activities mandated by the law must be provided to residents according to residents' individual needs, assessments, and care plans.

Transfer and discharge

Once a resident has been admitted to the facility, a facility's ability to transfer or discharge a resident is significantly restricted (F201/F202 §483.12(a)). It is therefore incumbent on the facility to only admit residents for whom it is capable of caring and to whom it can provide services, because discharge or transfer may be difficult, be time consuming, or require an extended period.

The following is a sample policy statement outlining a facility's obligations before it can discharge or transfer a resident.

Before a resident can be transferred, the facility must notify the resident at least 30 days prior to the anticipated transfer.

The 30-day discharge letter will be issued unless the administrator and director of nursing are in agreement and the physician documents the need for the discharge as prescribed in §483.12(a).

The facility will not transfer or discharge a resident except when

- 1.the transfer or discharge is necessary to meet the resident's welfare, and the resident's welfare cannot be met in the facility as documented by the *resident's physician*
- 2.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 as documented by the *resident's physician*
- 3.the safety of individuals in the facility is endangered, as documented by *any physician*
- 4.the health of individuals in the facility would otherwise be endangered as documented by *any physician*
- 5.the resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility
- 6.the facility ceases to operate

Transfer and discharge includes movement of a resident to a bed outside of the certified facility, even if that bed is in the same physical plant or campus.

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

This policy applies to transfers or discharges that are initiated by the facility, not by the resident.

Regardless of whether a resident agrees with the facility's decision, these policies apply whenever a facility initiates the transfer or discharge.

If a resident is living in a facility participating in both Medicare (skilled nursing facility [SNF]) and Medicaid (nursing facility [NF]) under separate provider agreements, a move from either the SNF or the NF constitutes a transfer.

Limitations on transfer for non-payment

A resident cannot be transferred for non-payment if the bill has been submitted to a third-party payer for payment.

Non-payment occurs if a third-party payer, including Medicare or Medicaid, denies the claim, and the resident, after being properly notified and advised of his or her right to appeal and exhaust all appeals, refuses to pay for his or her stay.

Right to refuse a room transfer

Every resident has the right to refuse a transfer to another room within the facility.

The refusal to accept the transfer does not affect the individual's eligibility or entitlement to Medicare or Medicaid benefits.

For example, a resident occupies a bed in a distinct part that is Medicaid-certified only; the resident may not be transferred involuntarily to the Medicare-certified unit to ensure Medicare eligibility for payment.

The facility is obligated to explain the availability of Medicare benefits in the other unit, but the resident is not required to move.

Such moves are only appropriate when they occur at the request of the resident or when a private-pay resident with potential Medicare benefits believes that admission to a bed in a Medicare-participating distinct part of the facility may result in Medicare payment.

Notification before transfer

The law requires that, before a transfer or discharge occurs, the facility notify the resident and, if known, the family member, surrogate, or representative, of the transfer and the reasons for it.

Because of the resident's right to appeal the transfer or discharge, the facility provides notice to the resident at the same time that it provides notice to all other parties involved with the resident. Facilities have lost appeals and their right to discharge a resident for any of the appropriate reasons (e.g., non-payment) on the technicality that the resident was not given notice in a proper or timely manner.

A copy or documentation of the notice is kept in the clinical record.

The written notice (§483.12(a)(6)) includes the following:

- The reason for transfer or discharge
- The effective date of transfer or discharge
- The location to which the resident is being transferred or discharged
- A statement that the resident has the right to appeal the action to the state, and the name, address, and telephone number of the state long-term care ombudsman
- Explanation of the right to appeal the transfer to the state
- In the case of a developmentally disabled individual, the notice must include the name, address, and phone number of the agency responsible for advocating for developmentally disabled individuals
- In the case of a mentally ill individual, the notice must include the name, address and phone number of the agency responsible for advocating for mentally ill individuals.

The notice of transfer or discharge must be given at least 30 days before the resident is transferred or discharged (§483.12(a)(5)).

Notice must be made as soon as practicable before transfer or discharge when (§483.12(a)(4))

- the safety of the individuals in the facility would be endangered
- the health of individuals in the facility would be endangered
- the resident's health improves sufficiently to allow a more immediate transfer or discharge
- an immediate transfer or discharge is required by the resident's urgent medical needs
- a resident has not resided in the facility for 30 days

Finally, the facility is required to provide sufficient preparation and orientation to residents to ensure safe and orderly discharge from the facility.

Assessment before transfer

Although transfer is to be avoided at all costs, there may be circumstances when it is necessary for the resident to be transferred.

If there is a significant change in condition, the resident should be reassessed to determine whether a change in the care and treatment plan would preclude transfer and allow the resident to remain in the facility.

The facility must avoid any indication of impropriety, including

- conversion from a private-pay rate to payment at the Medicaid rate does not constitute non-payment
- refusal of treatment would not constitute grounds for transfer, unless the facility is unable to meet the needs of the resident or to protect the health and safety of others
- a physician extender may complete documentation of the transfer/discharge unless prohibited by state law or facility policy

Preparation and orientation for discharge or transfer

Preparation and orientation is essential to ensure safe and orderly transfer or discharge from the facility.

Sufficient preparation means that the facility informs the resident where he or she is going and takes steps under its control to ensure safe transportation.

In addition, the facility involves the resident and the resident's family in selecting the new residence.

Bed-hold policy

The facility has a bed-hold and readmission policy that outlines the terms and conditions for holding a bed if the resident is transferred out of the facility for any reason.

The facility notifies the resident at the time of admission and again prior to a hospital transfer or therapeutic leave of its bed-hold and return policies.

Advance notice of the policy is given well before any transfer, usually at admission and in the admission packet. Re-issuance of the first notice is not required unless the facility's policy changes.

Notice of bed-hold policy and readmission is given to every resident and family member or legal representative. The notice specifies the following:

- The duration of the bed-hold policy under the state plan, if any, during which the resident is permitted to return and resume residence in the nursing facility
- The nursing facility's policies regarding bed-hold periods permitting a resident to return

- In cases of emergency transfer, notice at the time of transfer means that the family, surrogate, or representative is provided with written notification within 24 hours of the transfer
- The requirement is met if the resident's copy of the notice is sent with other papers accompanying the resident to the hospital

Readmission policy

The readmission policy addresses a resident's right to be readmitted following a transfer or discharge.

The policy addresses

- the right of readmission if a resident elects not to pay to hold the bed
- when a hospitalization or therapeutic leave exceeds the bed-hold period
- the fact that residents are permitted to return to the first available semi-private room at the facility, provided that the resident requires the services provided by the facility and is eligible for Medicaid nursing facility services

Medicaid-eligible residents on therapeutic leave or hospitalized beyond the state's bed-hold policy must be readmitted to the first available bed, even if the residents have outstanding Medicaid balances. Once readmitted, these residents may be transferred if the facility can demonstrate that non-payment of charges exists and if documentation and notice policies are followed.

The right to readmission applies to individuals seeking to return from a transfer or discharge as long as all qualifications are met.

Bed-hold payment policies and limitations

The facility can request payment to hold a bed from

- private-pay residents
- residents with long-term care insurance or other private insurance providing the policy contains coverage for bed holds. The facility needs to review each insurance policy to determine the level of benefits and whether the resident can be billed for the bed hold.

Medicare does not pay for bed holds. (Note, however, that the facility may ask the resident to pay for the bed hold. However, they must do so carefully so as not to conflict with Medicare rules

about paying for services. The facility should consult an attorney before asking Medicare beneficiaries to pay for bed holds.)

Medicaid may pay for a bed hold, but there is no uniform standard of Medicaid paying for bed holds—each state adopts its own policies, procedures, length of payment, and payment rates.

Bed hold for days in excess of the state's bed-hold limit is considered to be a “non-covered service,” meaning that residents can use their own income to pay for the bed hold.

Monitoring compliance

The director of nursing is responsible for monitoring compliance and ensuring that sufficient documentation exists to support an involuntary discharge or transfer.

The director of nursing should consider the following when monitoring compliance:

- Do records adequately document accurate assessments and care planning to address residents' needs?
- Have there been multidisciplinary interventions, accommodation of individual needs, and attention to the resident's customary routines?
- Did the resident's physician document whether the resident was transferred/discharged for the sake of the resident's welfare and the resident's needs could not be met in the facility?
- Did the resident's health improve to the extent that the transferred/discharged resident no longer needed the services of the facility?
- Has the resident been involved in a multi-disciplinary discharge planning process?
- Did a physician document whether the resident was transferred because the health of other individuals in the facility was endangered?
- Do the records of residents transferred/discharged due to safety reasons reflect the process by which the facility concluded that, in each instance, transfer or discharge was necessary?
- Were there any changes in source of payment that coincided with transfer?

All involuntary transfers and discharges should be reviewed at the facility's monthly continuous quality improvement (CQI) meeting.

Discharge planning

Discharge planning begins prior to the resident's admission and continues throughout the resident's stay.

Discharge planning identifies the resident's specific needs after discharge, such as personal care, sterile dressings, and physical therapy, and describes resident/caregiver education needs and the ability to meet care needs after discharge.

Discharge planning helps the facility determine whether the resident is capable of going to a less restrictive environment, such as assisted living, home, residential community, group home, or other community-based situation.

Discharge planning is a multidisciplinary approach involving the facility's staff, the resident, the responsible party, family members, friends, post-discharge caregivers, and support persons who will help the resident adjust to his or her new living environment.

The post-discharge plan takes into account the resident's and family's preferences for care, how the resident and family will access these services, and how care should be coordinated if continuing treatment involves multiple caregivers.