Center for Medicare Advocacy

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— Report —

Transfer and Discharge Deficiencies Cited Since 2017: Surveyors Focus On paperwork, Not Residents' Rights

The involuntary transfer and discharge of nursing home residents is the issue that nursing home ombudsman programs most often receive complaints about nationwide. In December 2017, the Centers for Medicare & Medicaid Services (CMS) announced an initiative "to examine and mitigate facility-initiated discharges that violate federal regulations."[1]

In August 2018, the Center for Medicare Advocacy reviewed the transfer and discharge deficiencies that have been cited since the new federal survey process went into effect in November 2017.[2] In the eight-month period between November 2017 and July 2018, 137 deficiencies in transfer or discharge were cited nationwide. The Center's study finds that only four of the 137 deficiencies were cited as either "harm" or "immediate jeopardy" and that the remaining 133 deficiencies were cited as "no-harm" or "substantial compliance." Most survey reports cited transfer and discharge solely as a paperwork problem, rather than as a serious issue involving violations of residents' rights to remain in their homes.

The CMS Initiative

The Survey & Certification Letter that announces the Initiative acknowledges the limited reasons for transfer and discharge that are permitted under the federal law[3] and regulations[4] and why noncompliance with these requirements matters.

> Discharges which violate federal regulations are of great concern because in some cases they can be unsafe and/or traumatic for residents and their families. These discharges may result in residents being uprooted from familiar settings; termination of relationships with staff and other residents; and residents may even be relocated long distances away, resulting in fewer visits from family and friends and isolation of the resident. In some cases, residents have become homeless or remain in hospitals for months.[5]

CMS also explains the various reasons why residents are involuntarily transferred or discharged.

> Analysis of federal deficiencies indicate that some discharges are driven by payment concerns, such as when Medicare or private pay residents shift to Medicaid as the payment source.[6] The most commonly reported reason that residents are discharged is due to behavioral, mental, and/or emotional expressions or indications of resident distress.

> Sometimes facilities discharge residents while the resident is hospitalized for health concerns unrelated to the behaviors that form the alleged basis for the discharge.[7]

Interventions under consideration by CMS to address deficiencies in transfer and discharge include "surveyor and provider training, intake and triage training, CMP-funded projects that may help prevent facility initiated discharges that violate federal regulations, and enforcement."[8]

Under CMS's initiative, Regional Offices are reviewing only transfer and discharge deficiencies that are cited following complaint investigations or annual surveys. They are not reviewing either administrative decisions made by hearing officers in residents' transfer and discharge appeals or complaints made to ombudsman programs.

This Report

The Center for Medicare Advocacy reviewed transfer and discharge deficiencies that have been cited since the new federal survey process went into effect on November 28, 2017. As of July 20, 2018, nationwide, 137 deficiencies for transfer/discharge (F622) have been cited.

The Center looked at the federal survey reports available on *Nursing Home Compare* for all of the substantial compliance (seven deficiencies), actual harm (three deficiencies), and immediate jeopardy deficiencies (one deficiency) and for a random sample[9] of 12 no-harm deficiencies (of 126 total no-harm deficiencies).

The primary finding of this analysis is that the majority of survey reports treated the deficiency as a paperwork problem and cited the deficiency as no harm. Surveyors did not typically investigate or document what happened after residents received notices that violated federal requirements. Missing or inadequate paperwork was cited as the sole issue of noncompliance. Surveyors generally did not follow up to determine whether residents were actually discharged without appropriate notice or for reasons not permitted by the law and regulations and, if so, what happened to them following discharge. In the few instances when surveyors did investigate the circumstances of the transfer or discharge, they appeared to treat the transfer or discharge far more seriously – as in the one immediate jeopardy deficiency and one of the harm deficiencies (both discussed below).

In addition, the Center found

- Most deficiencies (97%) were cited as no harm or substantial compliance (133 of 137 deficiencies).
- Only 1 deficiency was cited as jeopardy (less than .01%); three deficiencies were cited as actual harm (.02%).
- As noted in the tables below, only three facilities had civil money penalties imposed as a result of the survey that included a transfer/discharge deficiency. Two of these three facilities were cited with harm-level deficiencies in transfer/discharge following complaint surveys. The third facility was cited with a harm-level deficiency in supervision (based on a resident's fall from a lift when moved by one aide instead of two, fractured femur and fibula, hospitalization, and surgery).

- Close to 50% of the transfer/discharge deficiencies reviewed (10 of 23) were cited as a result of complaint surveys.
- Information about facilities' star ratings, not included in the charts below but available from the Center for Medicare Advocacy, indicates that as of August 30, 2018, facilities with overall star ratings and health survey ratings of one to five stars were cited with transfer/discharge deficiencies. Seven of the 23 facilities boosted their overall ratings because of high star ratings on their quality measures; one facility boosted its overall rating because of a high star rating on its staffing measure.[10]
- Some deficiencies were misclassified as transfer/discharge deficiencies (e.g., inappropriate documentation of resident's death).

Immediate jeopardy deficiency

A single immediate jeopardy deficiency has been cited since November 2017. Brookhaven Manor, a Special Focus Facility in Tennessee, was cited with immediate jeopardy at F622, in an annual survey completed March 21, 2018, based on the discharge of a resident to a hotel while his appeal of his discharge for alleged noncompliance with the facility's smoking policy was pending before a state hearing officer.

On December 21, 2017, a resident was given a Notice of Involuntary Discharge for violating the facility's smoking policy. The resident filed an appeal. In a February 2, 2018 conference call, the state Administrative Law Judge hearing his appeal issued a continuance of the appeal until February 21 so that the resident could get an attorney. When the resident was found smoking on Friday, February 9, the interim administrator (who had begun working at the facility on January 29) asked the resident for his matches or lighter. When the resident refused, he was sent to a hotel, driven in the facility's van. The facility paid for three nights at the hotel, which served breakfast, but facility staff did not know if the man had any money to pay for additional meals. The facility also failed to send all of the resident's prescribed medications with him to the hotel. The former resident told surveyors he had one meal on Friday and, as described in the survey report, "2 boxes of peanut butter crackers and some candy to eat for the following 3 days." Neither the resident's physician nor the facility's Medical Director had been consulted prior to the resident's discharge.

The state agency cited a total of six immediate jeopardy deficiencies related to the involuntary discharge, including, in addition to F622, deficiencies at F623 (failure to provide timely notification of discharge), F624 (failure to prepare resident for safe discharge), F745 (failure to provide medically-related social services), F835 (administration), F837 (governing body), and F867 (quality assurance and performance improvement). *Nursing Home Compare* does not report any CMP for these deficiencies and it is unknown whether any penalty for these deficiencies has been imposed and is under appeal.

All "Harm" Deficiencies for F622

Facility	State	Date and type of survey	Number of residents affected. Description of deficiency in survey report

Brush Hill Care Center	MA	2/13/2018 Complaint CMP: $121,373 2/13/2018	1 of 6 residents. Facility called police after resident hit another resident. Facility gave resident "No Trespass" order. Court released resident to shelter. Resident did not have any medications, prescriptions, or discharge paperwork. Shelter sent resident to hospital emergency department, where resident stayed for 3 days and nursing home refused readmission. Hospital case manager arranged for resident to go to shelter, with all prescriptions and taxi vouchers to get prescriptions and to shelter. Surveyors also cited F623.
Crawford Skilled Nursing	MA	12/8/2017 Annual	Survey report not available.
Harold and Grace Upjohn Community Care Center	MI	3/2/2018 Complaint CMP: $75,036 3/2/2018	17 of 26 residents. Facility was "downsizing," creating 56 updated private rooms (going from 118 to 76 residents), "resulting in feelings of sustained confusion, anger, frustration for residents and resident representatives." Survey report discusses 9 residents; describes serious mental decline and confusion in some of them following discharge. Surveyors also cited F623.

Random Sample of "No Harm" (Level D) Deficiencies for F622

Facility	**State**	**Date and type of survey**	**Number of residents affected. Description of deficiency in survey report**
Heartland Health Care Center of Ann Arbor	MI	3/21/2018 Complaint	1 of 2 residents. Emergency discharge to hospital (resident allegedly making homicidal threats against residents and staff); facility refusal to readmit; no physician documentation that resident's needs could not be met by facility or that facility attempted to meet resident's needs. Facility did not have a policy on involuntary discharge.
Magnolia Health and Rehabilitation	FL	1/30/2018 Complaint	1 of 3 residents. 30 day notice for safety of others, but behavioral health note says resident is not risk to others. Administrator said discharge was for noncompliance with smoking policy, but no care plan for smoking; no physician signature. Physician said facility discharged resident for refusing care, which physician said is resident's right.
Greenleaf Health Campus	IN	1/19/2018 Annual	1 resident. Resident transferred to psychiatric hospital for behaviors, but no physician orders. Surveyors also cited F625 (bed-hold) for 2 of 3 residents.

Olympia Transitional Care and Rehabilitation	WA	3/13/2018 Complaint	1 of 2 residents. Resident discharged to hospital for "behaviors" (aggressive towards staff, cursing, refusing care) so discharge necessary for safety of others and not allowed to return. No documentation in discharge summary of "behaviors," verbal aggression, or refusal of care. Director of Nursing said assignment of male staff was helpful. All documentation of "behaviors" was on day shift, most often, at 8:00 a.m.
Banning Health Care	CA	4/5/2018 Annual	2 of 3 residents. 1 resident transferred to acute psychiatric hospital; no documentation sent to hospital, in violation of facility policy. Other resident sent to Emergency Room without documentation (contact information, resident representative). Surveyors also cited F623 (no notification of resident representative or ombudsman), also in violation of facility policy
Hillside Heights Rehabilitation Suites	TX	1/12/2018 Complaint	1 of 5 residents. Facility failed to facilitate resident's request to transfer to another facility, resulting in 2-day delay in transfer.
Villa Maria Healthcare Center	CA	1/11/2018 Annual	1 of 3 residents. Resident discharged home, without final arrangements being made with home health agency. Former resident told surveyors she did not receive any home health care or therapy after discharge.
Aaron Manor Nursing & Rehabilitation	CT	3/1/2018 Annual CMP: $6500 3/1/2018	1 resident. Resident discharged home; discharge instructions not reviewed with resident or responsible party at time of discharge.
Heritage Health Care	IN	5/15/2018 Annual	2 of 5 residents. 2 residents transferred to acute care facility without appropriate transfer paperwork.
Knott County Health & Rehab	KY	12/5/2017 Complaint	1 of 3 residents. Physician order for discharge to hospital for psychiatric evaluation; resident discharged. Medical record did not include physician documentation of reason for discharge or of attempts to meet resident's needs in facility.
Mount Pleasant Manor	SC	2/16/2018 Annual	1 resident. Facility failed to record in medical records the resident's fall, which led to hospitalization. Facility did not communicate to hospital the reason for transfer of resident to hospital.

Marion Manor Nursing Home	OH	3/22/2018 Annual	4 of 4 residents. Facility failed to ensure appropriate information was communicated to hospital when each of 4 residents was sent to hospital. Surveyor also cited F623 (failure to notify resident's representative and local ombudsman, for 4 of 4 residents who were hospitalized).

All "Substantial Compliance" Deficiencies at F622

Facility	**State**	**Date and type of survey**	**Number of residents affected. Description of deficiency in survey report**
Ridgecrest Health Campus	MI	4/5/2018 Annual	1 of 2 residents. 1 resident discharged home with home health agency. Deficiency based on physician recapitulation of resident's stay not included in discharge papers.
Sunset Home	MO	12/20/2017 Annual	1 resident. Facility did not provide documentation of death information (who pronounced death, notification of next of kin).
Pearl Pavilion	IL	3/22/2018 Complaint	4 of 4 residents. No physician documentation that transfers were necessary or that residents' needs could not be met in facility. 1 resident sent to hospital; 1 to psychiatric hospital; 2 to emergency departments. Surveyors also cited F623 and F625 (bed-hold).
Central Continuing Care	NC	4/13/2018 Annual	1 of 1 resident. Facility did not provide notice of transfer to hospital to resident's representative; did not send copy of notice to ombudsman. Admissions Director and Administrator told surveyors they did not know about the requirements.
Baptist Homes of Western Pennsylvania	PA	2/24/28 Annual	2 of 2 closed record reviews. Residents discharged to personal care; discharge instructions for residents did not include information on how to contact ombudsman.
Hometown Nursing & Rehabilitation Center	PA	12/6/2017 Complaint	1 of 3 residents Facility said discharge because of resident's welfare and needs could not be met. Survey report says specific reasons were "resident did not cooperate, refused psychiatric evaluation, refused to be compliant with overall care and that she contacted 911." Surveyors also cited F623.
Barnes Healthcare	AR	12/14/2017 Complaint	1 resident. Resident given discharge notice because he used his electric wheelchair in unsafe manner (especially when

			he took certain medications, which he said he would stop taking), cursing, complaining that call bells not answered. Many facilities refused him admission, except for 1-star facility, which he refused.

Recommendations

The Centers for Medicare & Medicaid Services needs to give additional direction to state agency surveyors in how to investigate issues involving involuntary transfer and discharge. CMS must require surveyors to determine whether residents were actually transferred or discharged and, if so, the circumstances of their transfer or discharge and what happened to them after their transfer or discharge, including whether they were allowed to return to their facilities. Reviewing only a facility's paperwork is not sufficient.

CMS also must define severity levels more clearly, specifically, when harm or jeopardy should be cited. When a resident is transferred or discharged for an impermissible reason (e.g., Medicare coverage ends, transition from private-pay to Medicaid, resident complains and resists care), to an unsafe location (e.g., homeless shelter, hotel), without adequate preparation, while an appeal is pending, or is denied the right to return to the facility, the deficiency should be cited at least as actual harm. Noncompliance should be cited as no-harm or substantial compliance only when there were problems in the paperwork but the facility otherwise actually complied with all federal transfer and discharge requirements.

Additional guidance about appropriate remedies should require facilities to readmit residents who win their administrative appeals. States and CMS should not accept plans of correction that do not include readmission; alternatively, states and CMS should mandate readmission in directed plans of correction.

Finally, Regional Offices need to expand their reviews of transfer and discharge issues under the CMS initiative. In addition to deficiencies in transfer and discharge that are cited as a result of complaints or annual surveys, Regional Offices need to receive and review at least a sample of decisions by Administrative Law Judges. They should also be consulting with state ombudsman programs to better understand the scope of the problem and develop meaningful solutions.

Conclusion

The overwhelming percentage of deficiencies in transfer and discharge that are cited as no harm or substantial compliance reflects state survey agencies' and CMS's not identifying and documenting the serious consequences that involuntary transfers and discharges have for residents. State survey agencies must fully investigate these deficiencies, go beyond the paperwork problems these deficiencies represent, and ensure that facilities attain and maintain full compliance with all requirements.

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[1] CMS, "An Initiative to Address Facility Initiated Discharges that Violate Federal Regulations," S&C: 18-08-NH (Dec. 22, 2017), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-18-08.pdf.
[2] CMS, "Preparation for Launch of New Long-Term Care Survey Process (LTCSP)," S&C: 18-05-NH (Nov. 24, 2017), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-18-05.pdf.
[3] 42 U.S.C. §1395i-3(c)(2)(A)-(C), 1396r(c)(2)(A)-(D), Medicare and Medicaid, respectively.
[4] 42 C.F.R. §483.15(c)(1)(i)(A)-(F).
[5] CMS, "An Initiative to Address Facility Initiated Discharges that Violate Federal Regulations," S&C: 18-08-NH (Dec. 22, 2017), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-18-08.pdf.
[6] Whether Medicare will pay for a resident's care is one issue, governed by Medicare payment policy. Whether the resident must leave the facility is a separate issue, governed by the Nursing Home Reform Law. *See* Center for Medicare Advocacy, "'Discharge from a Skilled Nursing Facility: What Does It Mean and What Rights Does a Resident Have?" (CMA Alert, Jan. 13, 2016). http://www.medicareadvocacy.org/discharge-from-a-skilled-nursing-facility-what-does-it-mean-and-what-rights-does-a-resident-have/.
[7] *Id.*
[8] *Id.*
[9] The Center looked at the list of facilities with transfer/discharge deficiencies on data.medicare/gov. Starting on the fifth no-harm deficiency, the Center looked at *Nursing Home Compare* for facilities that were 5th, 15th, 25th, etc. on the list.
[10] The Center for Medicare Advocacy has written about the phenomenon of facilities boosting their overall ratings by getting five stars in their quality measures. *See* CMA, "Nursing Facilities' 'Quality Measures' Do Not Reflect Actual Quality of Care Provided to Residents" (Alert, Aug. 9, 2018), http://www.medicareadvocacy.org/nursing-facilities-quality-measures-do-not-reflect-actual-quality-of-care-provided-to-residents/.