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Concerns Remain About Safeguards To Protect Residents During Facility-Initiated Discharges From Nursing Homes

Christi A. Grimm
Inspector General
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REPORT HIGHLIGHTS

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Concerns Remain About Safeguards To Protect Residents During Facility-Initiated Discharges From Nursing Homes

Why OIG Did This Review

- Facility-initiated discharges that do not follow Federal regulations can be unsafe and traumatic, leading to resident harm.
- CMS and State Long-Term Care Ombudsmen have raised concerns about the extent to which nursing homes follow Federal requirements for these discharges.
- This review provides insights into a sample of facility-initiated discharges from nursing homes and the extent to which these discharges followed Federal requirements.

What OIG Found

In most (107 out of 126) of the facility-initiated discharge cases in our review, nursing homes discharged residents for allowable reasons; however, our review raises concerns about nursing homes' understanding of and compliance with notice and documentation requirements for facility-initiated discharges.

- **Nursing homes sometimes fell short in providing required documentation**, such as documentation that the receiving facility could provide services that meet residents' needs.

- **Nursing homes often failed to notify residents of their discharges and frequently omitted required information in notices**, which may have compromised residents' rights and abilities to plan for safe transitions.

- **Even when nursing homes provided the resident with a facility-initiated discharge notice, only about half sent a copy of the notice to the Ombudsman, as required**, potentially impeding the Ombudsman's ability to effectively advocate for residents.

We also found that nursing homes struggled to identify facility-initiated discharges, which may present CMS and State survey agencies with challenges in overseeing these discharges during the survey process.

What OIG Recommends

1. CMS provide a standard notice template to help nursing homes provide complete and accurate information to residents facing discharge and Ombudsmen.
2. CMS require nursing homes to systematically document facility-initiated discharges in information available to CMS and States to enhance oversight.

CMS did not explicitly state its concurrence or nonconcurrence for the two recommendations.

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BACKGROUND

OBJECTIVE

To assess the extent to which nursing homes comply with Federal requirements for facility-initiated discharges.

Inappropriate facility-initiated discharges from nursing homes (i.e., discharges that nursing homes initiate that do not comply with Federal regulations) can undermine the safety and care of residents. The Social Security Act, as amended by the Nursing Home Reform Act of 1987, includes protections for residents against these discharges. However, stakeholders, advocates, and some news reports have raised concerns about inappropriate facility-initiated discharges and the extent to which these are being addressed. For example, one media report described a case in which a nursing home discharged a resident with dementia to an unlicensed boardinghouse. The resident ended up wandering away from the boardinghouse. His nephew then took him in but could not provide the appropriate level of care.[1] Another report detailed a case in which a nursing home dropped off a resident with dementia in front of her son's home without ensuring that she safely entered the home.[2]

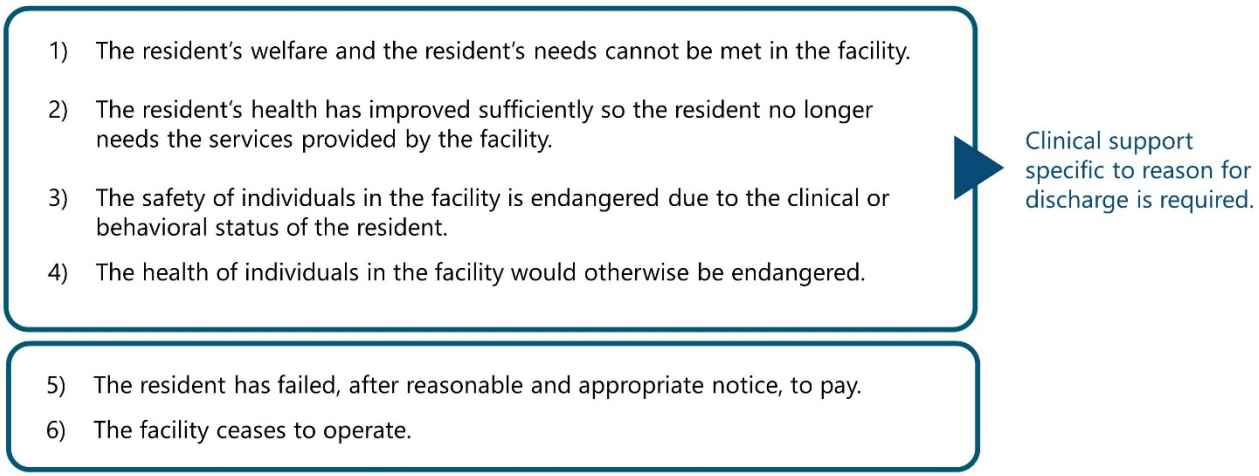
Notably, nursing homes can appropriately discharge residents if the discharge is for an allowable reason and the nursing home adheres to Federal requirements. For example, a nursing home may discharge a resident to another nursing home if the original nursing home cannot meet the resident's needs. This discharge would be appropriate if the original nursing home properly documents the needs that cannot be met and the services available at the receiving nursing home to meet those needs, among other requirements.[3]

Our earlier report on facility-initiated discharges from the Office of Inspector General (OIG) found that the Centers for Medicare & Medicaid Services (CMS), charged with overseeing and enforcing Federal nursing home regulations, has limited insight into these discharges. Nursing homes do not identify these discharges on documentation submitted to CMS, and although nursing homes are required to send a copy of the facility-initiated discharge notice to their State Long-Term Care Ombudsman (Ombudsman), the Ombudsmen do not always track these notices or share this information with CMS. This report further examines facility-initiated discharges by assessing a sample of these cases for their compliance with Federal regulations.

Federal Regulations for Facility-Initiated Discharges in Nursing Homes

CMS defines a facility-initiated discharge as a discharge that "the resident objects to, or did not originate through a resident's verbal or written request, and/or is not in alignment with the resident's stated goals for care and preferences." Nursing homes also do not expect the resident to return to the facility in the case of a facility-initiated discharge.[4] Federal regulations allow nursing homes to initiate discharges of residents for six specific reasons (see Exhibit 1).

Exhibit 1: Nursing homes may only initiate the discharge of a resident for six reasons, four of which need clinical support to validate the reason



Source: 42 CFR § 483.15(c)(1)-(2).

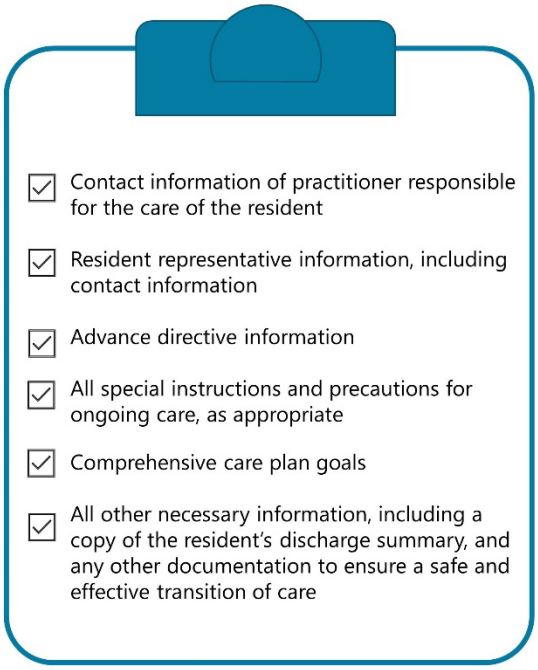
CMS requires nursing homes to include specific documentation in the medical record in cases of facility-initiated discharges. In its 2016 final rule, CMS indicates that the purpose of these requirements is to enhance resident care and safety by improving communication between providers during transitions of care.[5] Prior to discharging a resident, nursing homes must document the reason for the facility-initiated discharge in the resident's medical record.[6] Furthermore, the medical record must have documentation that validates the reason for discharge. Four of these reasons relate to the clinical or behavioral status of the resident and require clinical support in the medical record to validate the reason for discharge.[7]

Nursing homes must include additional documentation in the medical record if a resident is discharged because the nursing home cannot meet the resident's needs. In these cases, nursing homes must document the specific needs that cannot be met, the nursing home's attempts to meet those needs, and the services available at the receiving facility to meet the needs of the resident.[8]

Furthermore, CMS requires that nursing homes provide certain documentation to the receiving facility when they discharge a resident to another nursing home or other provider (see Exhibit 2).

CMS updated its guidance to surveyors on facility-initiated discharges in October 2022 and February 2023. As part of its updates, CMS clarified situations that constitute a facility-initiated discharge, such as including cases in which the nursing home pressured the resident to leave the facility. CMS also provided additional clarification on emergency transfers to acute care facilities, emphasizing that these situations are generally considered facility-initiated transfers (rather than discharges) because the resident is expected to return to the nursing home.[9] Furthermore, CMS clarified its expectations for facility-initiated discharge notices.[10] CMS included additional updates and clarifications in these versions of its guidance.

Exhibit 2: When discharging a resident to another facility, nursing homes must provide certain documentation to the receiving facility



Source: 42 CFR § 483.15(c)(2)(iii).

Notice Requirements for Facility-Initiated Discharges

Nursing homes must notify the resident and the resident's representative in writing before discharging the resident. CMS also requires that nursing homes send a copy of the notice to their State Ombudsman prior to discharging a resident.[11] The State Long-Term Care Ombudsman Program, authorized by the Older Americans Act, advocates on behalf of nursing home residents to resolve problems with their safety, welfare, and rights.[12] CMS instructs nursing homes to send a facility-initiated notice to the Ombudsman at the same time that nursing homes provide the notice to the resident.[13] The intent of this requirement is as follows: CMS wants to both ensure that the Ombudsman is aware of nursing home discharge practices and help protect residents from inappropriate discharges by providing residents access to an advocate.

CMS requires that written notices to residents and Ombudsmen for facility-initiated discharges contain specific information, including the reason for and location of the discharge, among other information (see Exhibit 3 on the next page). CMS also requires the notice to include, when appropriate, contact information for agencies

responsible for the protection and advocacy of individuals with intellectual and developmental disabilities and/or a mental disorder or related disabilities.[14]

Exhibit 3: Nursing homes must include specific information in notices for facility-initiated discharges

Reason for discharge

Specific location to which the resident will be moved

Date of discharge

A statement about the resident's rights to appeal the discharge

Information on how to obtain an appeal form and assistance in completing the form and submitting the appeal

Contact information for:
1) The entity that receives appeals
2) The State Ombudsman
3) Agencies responsible for the protection and advocacy of individuals with developmental disabilities and/or mental disorder, when appropriate

Source: 42 CFR § 483.15(c)(5).

If information in the notice changes prior to the discharge date, the nursing home must update the resident and/or resident's representative, as well as the State Ombudsman, as soon as possible with this new information.[15] According to CMS guidance, nursing homes must provide a new notice and reset the discharge date to allow 30 days' notice when significant changes are made to the discharge, such as a change in the discharge location.[16]

CMS requires that nursing homes provide the written notice of discharge at least 30 days before the date of discharge but allows for exceptions. The nursing home only needs to provide notice as soon as practicable before the discharge in the following cases: (1) the resident endangers the safety or health of others in the nursing home, (2) the resident's heath improves, (3) the resident requires a more immediate discharge to meet his/her needs, or (4) the resident has not resided in the nursing home for 30 days.[17]

State Administrative Hearings

Residents may appeal a facility-initiated discharge through an administrative hearing if they believe the discharge does not meet requirements.[18] Ombudsmen can assist a resident with the appeal process if the resident consents to that assistance. Federal regulations prohibit nursing homes from discharging residents while an appeal is pending, except under certain conditions. For example, if the resident poses a danger to the health or safety of other individuals in the nursing home, the nursing home may discharge the resident while an appeal is pending but must document the specific danger that the resident poses in the medical record.[19]

Related OIG Work

This study is part of OIG's larger body of work examining nursing home resident safety and oversight. Most recently, OIG published a report examining CMS's efforts to work with State agencies to improve nursing home oversight.[20] OIG also published reports examining CMS's and State agencies' onsite oversight of nursing homes during the COVID-19 pandemic, staffing levels in nursing homes, and States' timeliness investigating the most serious nursing home complaints.[21, 22, 23]

This current report is associated with and complements the OIG report on facility-initiated discharges issued in 2021.[24] In that report, we recommended that CMS provide training to nursing homes, assess the effectiveness of its enforcement, and implement its deferred initiatives to address inappropriate facility-initiated discharges. Lastly, an OIG data brief accompanies this report and describes the 126 facility-initiated discharges, including the reasons for discharge, interventions nursing homes used to prevent discharges, and the location to which residents were discharged.[25] A complete listing of OIG's ongoing evaluations and audits is available in our online Work Plan at https://www.oig.hhs.gov/.

Methodology

Scope

We considered facility-initiated discharges from both Medicare- and Medicaid-certified nursing homes in our review. Our review refers to the last 6 months of calendar year 2019, which is when the latest data were available that did not overlap with the COVID-19 pandemic.

Data Sources

Our review includes the following data sources: (1) medical records for a sample of residents who were subject to facility-initiated discharges between July and December 2019 and (2) data and interviews from Ombudsmen. Our sample of residents was selected through an electronic survey of Ombudsmen and nursing homes.

Sample Selection. For this multistage design, we first selected Ombudsmen by State and later selected nursing homes within these States. We selected a purposive sample of Ombudsmen from 13 States that could provide us data on facility-initiated discharge notices for our review. These Ombudsmen provided a list of 820 nursing homes that sent facility-initiated discharge notices to them. We then stratified the States (represented by the Ombudsmen) based on the number of nursing homes in each State and selected a sample of 329 total nursing homes. In total, 130 of the 329 nursing homes provided 470 initial cases of what they identified as facility-initiated discharges. Upon review, we found that hundreds of these cases did not qualify for this study and excluded 344 cases from 48 nursing homes.[26] Ultimately, 82 nursing homes identified the 126 resident facility-initiated discharges included in our review.

Followup With Ombudsmen. Of the 329 nursing homes that we contacted for facility-initiated discharges, 164 told us that they did not initiate a discharge from July 1 through December 31, 2019.[27] Due to this discrepancy with the information provided by the Ombudsmen, we wanted to confirm that these nursing homes did send a facility-initiated discharge notice to the Ombudsmen during this time period. In September and October 2021, we contacted the 13 Ombudsmen from which we obtained our sample and asked them to confirm that they received a facility-initiated discharge notice from the 164 nursing homes that told us they did not initiate any facility-initiated discharges during our study's timeframe. We also interviewed nine of these Ombudsmen to ask about the discrepancies between the information the Ombudsmen and nursing homes provided about the facility-initiated discharges.

Medical Record Review. Nurses and physicians reviewed the medical records of 126 residents that the 82 nursing homes provided as facility-initiated discharges during our study's timeframe. We requested the medical records directly from the nursing homes. The nurse and physician reviewers followed structured protocols that we developed in consultation with the reviewers and physician experts in long-term care. The protocols included questions about documentation requirements, support in the medical record for the discharge reason, and the resident's clinical status and conditions. The goal of the medical record review was to determine whether the nursing homes followed Federal regulations for initiating the discharge of a resident.

Analysis

We analyzed the results of the nurse reviews to determine the extent to which the facility-initiated discharges in our sample complied with Federal requirements. For example, we determined the number of cases without a facility-initiated discharge notice or missing required information on the notice. Furthermore, we analyzed the physician reviews to determine whether the nursing home supported the reason for discharge. Finally, we examined the nurse reviews for questions about the reason for discharge and whether the nursing home provided support for the reason.

We also analyzed the open-ended results of the nurse and physician reviews for the facility-initiated discharge cases within our sample. Specifically, we examined the circumstances around the discharge and Ombudsman involvement. We conducted

qualitative analysis and categorized responses by theme to identify patterns across the residents in our sample.

Finally, we analyzed responses from our followup with the Ombudsmen. Specifically, we determined how many nursing homes that told us that they did not initiate a discharge from July 1 through December 31, 2019, did, in fact, send a facility-initiated discharge notice to their Ombudsmen during that timeframe. We also examined data from our interviews with nine Ombudsmen to identify potential reasons for this discrepancy.

See Detailed Methodology for further information.

Limitations

We did not independently verify the survey responses that Ombudsmen or nursing homes provided. The results of the medical record review are not projectable to the population of facility-initiated discharges; our results apply only to the sample of 126 facility-initiated discharges reviewed for this report. Moreover, the results of our medical record reviews of the facility-initiated discharges are limited to the documentation that nursing homes provided at the time of our review. In addition, the results were subject to the interpretations and clinical judgments of the nurse and physician reviewers.

Standards

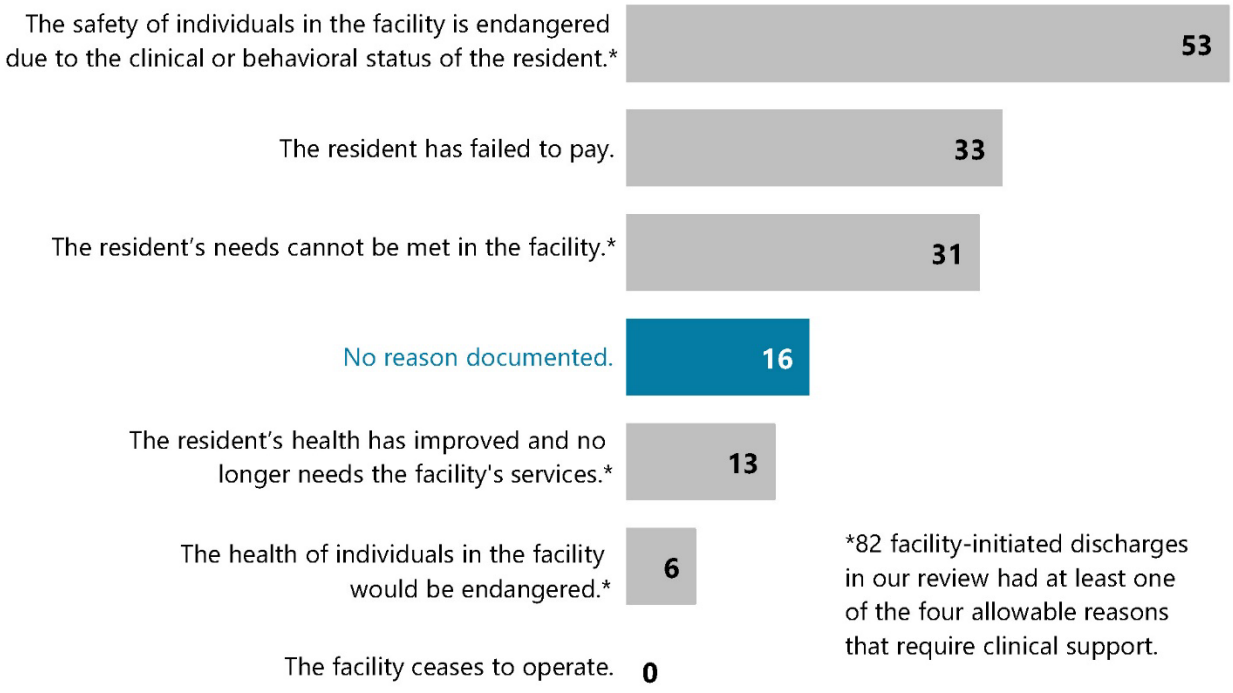
We conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

In most (107 of 126) of the facility-initiated discharge cases in our review, nursing homes discharged residents for allowable reasons; however, nursing homes sometimes fell short in providing required documentation

Nursing homes discharged residents for one of the six allowable reasons in most of the cases in our review. In some cases, nursing homes cited more than one allowable reason for discharge. However, in 16 of the 126 cases in our review, nursing homes did not document a reason for discharge in the medical record (see Exhibit 4). In these cases, nursing homes may have violated residents' rights if the discharges were for unallowable reasons.

Exhibit 4: Nursing homes did not document a reason for discharge for 16 of the 126 facility-initiated discharges in our review



Source: OIG analysis of medical record review data, 2023.
Note: In some facility-initiated discharges, nursing homes discharged a resident for more than one allowable reason, and each was counted separately.

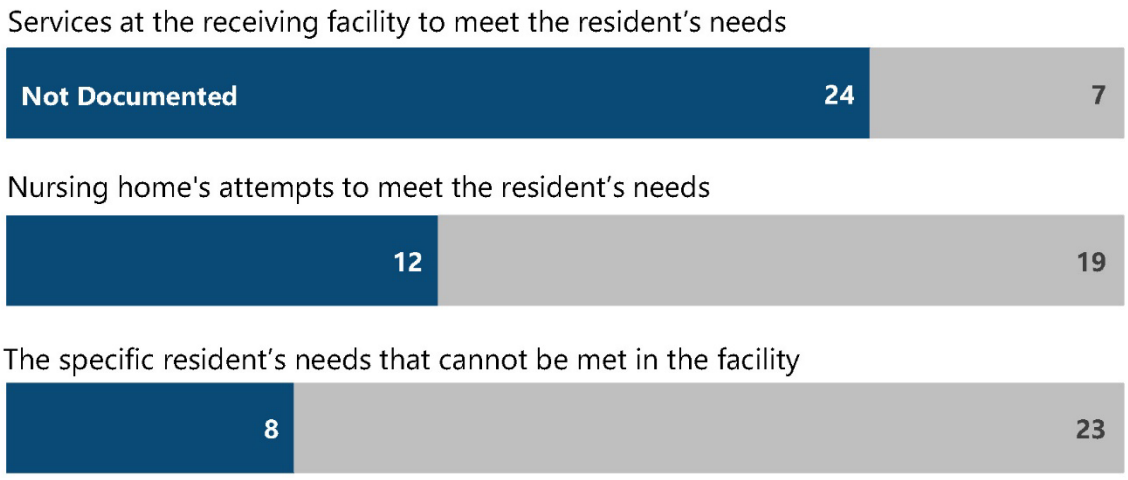
Nursing homes provided sufficient clinical support for all but 3 of the 82 discharges in our review that required it. In one case in which the nursing home did not provide

adequate support, the nursing home stated that it discharged the resident because it could not meet the resident's needs. Specifically, the nursing home claimed that it had to discharge the resident because it did not have the specific ventilator to support the resident's breathing. However, our physician reviewer determined that the nursing home could have used a different ventilator that was available at the facility to meet the resident's needs. For the other two cases, the nursing home did not provide enough documentation for physician reviewers to determine whether the nursing home adequately supported the reason for discharge.

82 facility-initiated discharges in our review had at least one of the four allowable reasons that require clinical support to validate the reason. See Exhibit 4 above for these.

In addition, nursing homes failed to document required information about other aspects of the discharge, raising questions about the compliance of some discharges in our review. For example, when initiating a discharge for not being able to meet the resident's needs, nursing homes must document services available at the receiving facility that can meet these needs. However, in about three-fourths of these cases (24 of 31), nursing homes failed to provide this documentation (see Exhibit 5). Likewise, in some cases in which the nursing home claimed it could not meet the resident's needs, it failed to document attempts to meet these needs (12 of 31 cases) or the specific needs of the resident that it could not meet (8 of 31 cases). Without this documentation, it is unclear why these nursing homes could not meet residents' needs, or whether these nursing homes discharged residents to facilities that could provide the residents with appropriate care.

Exhibit 5: Nursing homes fell short in documenting required information when discharging residents for not being able to meet their needs (n=31)



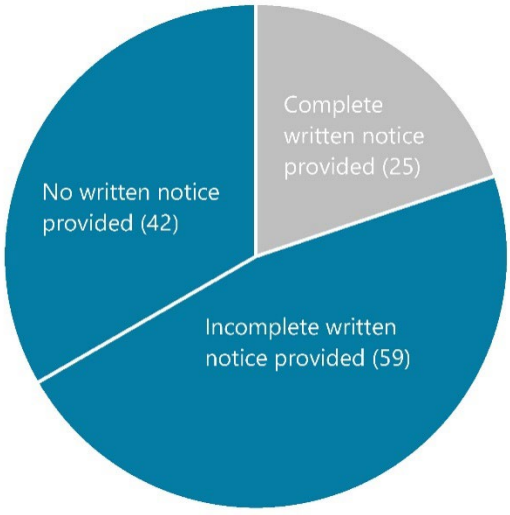
Source: OIG analysis of medical record review data, 2023.

Nursing homes may have compromised residents' rights and abilities to plan for a safe transition by not adhering to notice requirements for facility-initiated discharges

CMS requires nursing homes to provide written notice to residents of facility-initiated discharges generally 30 days prior to the discharge. Providing this notice allows residents to respond to and plan for the discharge to ensure a safe transition from the nursing home. Indeed, nursing homes are required to include information on the notice for resources that the resident can access to assist with the discharge, such as information about appeals and contact information for the State Ombudsman. Although nursing homes generally documented and supported an allowed reason for discharge in the medical record, their noncompliance with notice requirements raises concerns about residents' rights and ability to respond to and plan for discharge.

Nursing homes did not provide a complete written notice to more than three-quarters of residents in our review, undermining a resident's rights and ability to appeal or plan for discharge

Exhibit 6: Nursing homes did not provide a complete written notice of facility-initiated discharge to more than three-quarters of residents in our review (n=126)



Source: OIG analysis of medical record review data, 2023.

Nursing homes did not notify residents in writing of their discharges in one-third (42 of 126) of the facility-initiated discharge cases reviewed (see Exhibit 6). Failure to provide a notice to the resident could impede the resident's ability to plan for a safe transition of care. In one example, a nursing home sent a resident to an acute care hospital for evaluation and later failed to provide the resident with a written notice of discharge to clarify that the resident could not return to the nursing home. The lack of written notice in this situation not only caused confusion but also may have led to delays in both the resident's and the hospital's ability to plan for safe transfer to a different location.

Nursing home residents who do not receive information on how to appeal a facility-initiated discharge may be less likely to exercise that right.

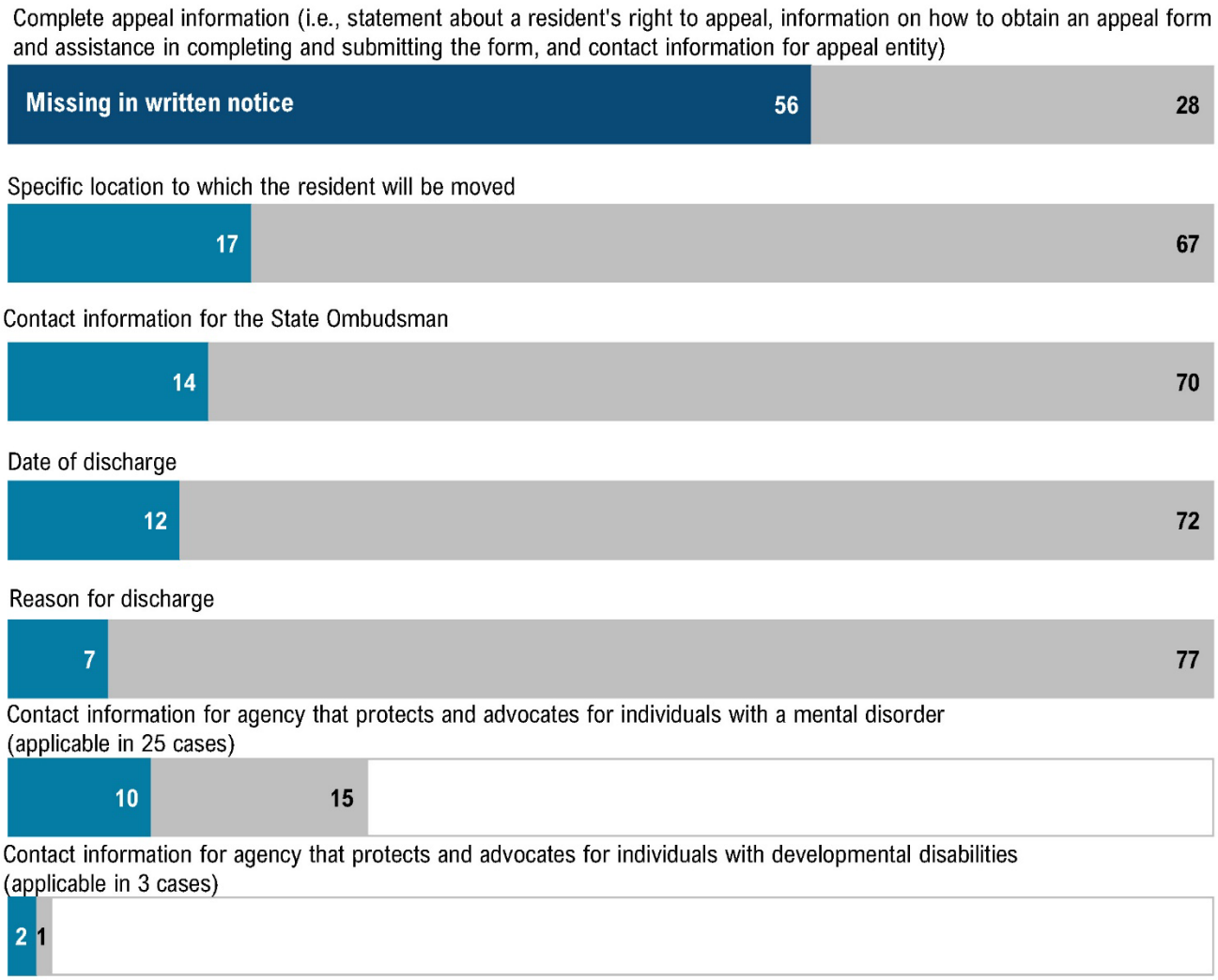
Most written discharge notices were missing at least one required element. Of the 84 facility-initiated discharge cases in which nursing homes provided written notice to residents, 59 were missing at least one required element (see Exhibit 6). Most commonly, nursing homes did not provide complete information for a resident to appeal the facility-initiated discharge, as required (see Exhibit 7 on the next page). For example, residents have a right to appeal a discharge to the designated entity in the State. Receiving this information on the facility-initiated discharge notice may lead residents to file appeals. In fact, of the 11 facility-initiated discharge cases in our review with an appeal, the residents received required information about their appeal rights in 10 of these cases. In one case in which the resident received appeal rights information on the notice, the resident hired the State's Legal Aid to represent her at the appeal.

The ability to appeal a facility-initiated discharge is important and can protect residents even when the discharge is upheld. For example, as a result of the appeal ruling in one case, the nursing home was required to help find appropriate placement for the resident and extend the resident's discharge date. In another case, the nursing home changed the reason for the discharge in the notice and failed to provide an additional 30 days from the date of the change before discharging the resident, as required. The resident appealed and the facility-initiated discharge was upheld, but the nursing home had to extend the resident's discharge date, giving the resident more time to prepare for a safe transition out of the nursing home.

Missing or vague discharge locations in the notice, such as "another nursing home" or "to a place of your [the resident's] choice" raise questions about discharge planning.

In 17 of the 84 cases we reviewed with written notices, nursing homes failed to specify the location to which the nursing home would discharge the resident (see Exhibit 7 on the next page). Moreover, some nursing homes provided vague locations in the notice, such as "another nursing home" or "to a place of your [the resident's] choice." A missing or vague discharge location in the notice not only may make it difficult for residents and their families to plan for the next stages of care but also raises questions about nursing homes' discharge planning. Without a specific discharge location, it is unclear whether the nursing home properly arranged for the resident to go to a safe and appropriate location. In one of these cases, the nursing home discharged a resident with end-stage renal disease who required dialysis. This nursing home failed to provide a discharge location on the notice and ended up discharging the resident to an unspecified hotel, possibly leading to a significant safety risk for the resident.

Exhibit 7: Nursing homes most often did not include complete appeal information in the written notice, as required (n=84)



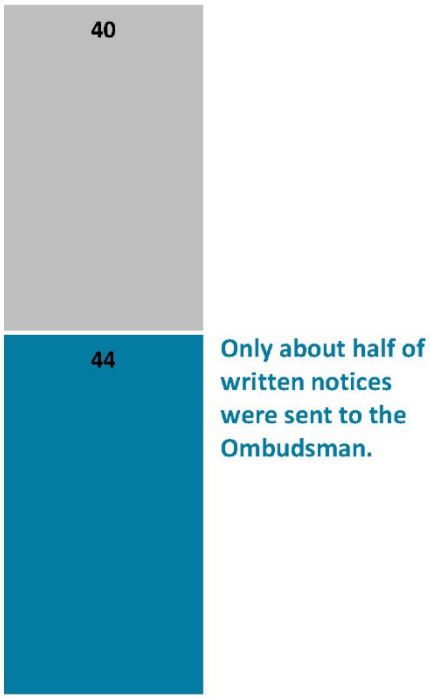
Source: OIG analysis of medical record review data, 2023.

Incomplete notices not only impede residents' abilities to contest or plan for the discharge but also present challenges to the Ombudsman in their role of advocating for residents. In our 2021 report on facility-initiated discharges, we reported that many Ombudsmen thought nursing homes in their States did not have a clear understanding of CMS's requirements for facility-initiated discharge notices. Similar to our findings about the notices provided to residents, Ombudsmen told us that nursing homes did not always provide a reason or specific discharge location on notices they received. In addition, almost all Ombudsmen found receiving incomplete notices was a challenge to investigating discharges.

Furthermore, even when nursing homes in our review provided the resident with a facility-initiated discharge notice, only about half sent a copy of the notice to the Ombudsman, as required, potentially impeding the Ombudsman's abilities to effectively advocate for residents

For the 84 cases in which nursing homes provided a written notice of discharge to the resident, the nursing home sent a copy of the notice to the Ombudsman, as required, in only 44 of these cases (see Exhibit 8). In one case, the nursing home discharged the resident for failure to pay but did not send the notice to the Ombudsman, as required. This may have hindered the Ombudsman's efforts to assist the resident with payment applications or to help with a safe transition of care.

Exhibit 8: When nursing homes in our review provided the resident with a facility-initiated discharge notice, only about half sent a copy of the notice to the Ombudsman, as required (n=84)



Source: OIG analysis of medical record review data, 2023.

The role of the Ombudsman is to advocate for residents in nursing homes and protect their rights. In 2016, CMS required that nursing homes send a copy of the facility-initiated discharge notice to the Ombudsman so that the Ombudsman can know when these discharges are happening and assist residents in responding to discharges.[28] Some cases in our review included documentation of the Ombudsman assisting residents. In one of these cases, the Ombudsman agreed with the discharge and helped find a new placement for the resident. In other cases, the Ombudsman visited the resident and/or participated in a care conference. The fact that nearly half of the nursing homes that provided notices to residents did not provide these notices to the Ombudsman undermines CMS's goal of providing protections to residents experiencing facility-initiated discharges.

Moreover, nursing homes' failure to send a copy of these notices hinders efforts by Ombudsmen to systematically track facility-initiated discharges in their States. Although our 2021 report found that the Administration for Community Living and CMS do not track facility-initiated discharge notices, some Ombudsmen do track the notices they receive and, in some cases, contact every resident for whom they receive

notices. CMS requires nursing homes to send notices to Ombudsmen, in part, so that Ombudsmen are aware of nursing home discharge practices. Thus, without notices, Ombudsmen have limited ability to track and collect information on facility-initiated discharges in their States, or to potentially flag concerning patterns to bring to the attention of State survey agencies or CMS. This may also result in lost opportunities for Ombudsmen to directly contact and assist residents.

Nursing homes struggled to identify facility-initiated discharges, which may present challenges to overseeing these discharges

When collecting our sample of facility-initiated discharges, we found that nursing homes had difficulty responding to our request and, in many cases, could not identify any facility-initiated discharges. Specifically, 134 nursing homes that told us they did not initiate a discharge during our review period did, in fact, send at least one facility-initiated discharge notice to their Ombudsman during this time. CMS does not require that nursing homes maintain a list of all facility-initiated discharges. Instead, nursing homes document the discharge in individual resident medical records. In fact, some nursing homes told us they relied on institutional knowledge or a review of all discharges to identify those that they initiated.

134 nursing homes that told us they did not initiate a discharge did, in fact, send a facility-initiated discharge notice to their Ombudsman.

In addition, we found that some nursing homes could not differentiate facility-initiated discharges from other types of discharges. For example, some nursing homes incorrectly identified cases as facility-initiated when the medical record indicated that the resident or family requested the discharge. Ombudsmen, too, reported that nursing homes are confused about what situations constitute a facility-initiated discharge. For example, one Ombudsman told us that many nursing homes incorrectly think that a resident must appeal the discharge for it to be considered facility-initiated. This confusion raises questions about the extent to which facility-initiated discharges occur without the nursing home providing any notice or documentation.

Inability to accurately identify facility-initiated discharges may present challenges to overseeing that residents' rights are protected and that residents receive a safe transition out of nursing homes. Nursing homes that cannot identify these discharges may hinder the survey process and increase surveyors' workload. According to CMS, surveyors select one "unplanned" discharge (typically a facility-initiated discharge, but unplanned discharges also include certain resident-initiated discharges as well as acute-care transfers to hospitals) to review in each recertification survey.[29] If surveyors select a facility-initiated discharge and find concerns with it, they ask the nursing home to identify other facility-initiated discharges for review. If a nursing home does not provide any, surveyors review all discharges from the nursing home in

the prior 3 months. The complexity of some discharges makes this review time intensive. This suggests that if nursing homes incorrectly identify facility-initiated discharges and provide other types of discharges to surveyors, surveyors may spend unnecessary time reviewing these discharges, while cases that do qualify as facility-initiated discharges could elude oversight.

CONCLUSION AND RECOMMENDATIONS

In addition to protecting residents at risk from the harms of inappropriate facility-initiated discharges, CMS is responsible for ensuring that nursing homes protect residents' rights, safety, and well-being when initiating these discharges. Although we found that most of the 126 facility-initiated discharges in our sample were for appropriate reasons, nursing homes did not consistently comply with requirements that CMS enacted to protect residents during these discharges. Furthermore, nursing homes' inability to identify facility-initiated discharges has implications for oversight.

These findings build upon related work and reinforce our call for further attention to facility-initiated discharges in nursing homes. Our earlier report, published in 2021, not only found that the magnitude of facility-initiated discharges remains unknown but also that the safeguards to protect residents from inappropriate discharges need improvement. Our current report underscores both the continued challenge in identifying these discharges as well as the continued concerns about safeguards for residents. Moreover, our companion data brief, *Nursing Home Residents with Mental Health and Behavioral Disorders May be Vulnerable to Facility-Initiated Discharges* (OEI-01-18-00052), found that residents with mental health disorders may be at risk for facility-initiated discharges. This raises crucial questions about nursing homes' ability to care for these residents.

Better ensuring that nursing homes correctly identify facility-initiated discharges and comply with regulatory requirements will help to protect residents' rights, safety, and well-being during these discharges. Therefore, we recommend that CMS:

Provide a standard notice template to help nursing homes provide complete and accurate information to residents facing discharge and Ombudsmen

A template notification can serve as a resource for nursing homes while helping residents facing discharge receive complete and accurate information. The template should include instructions and definitions that help nursing homes provide the information that CMS requires to be in the notice. For example, the template should instruct nursing homes to provide the specific discharge location. It could also include examples of common situations that qualify as facility-initiated discharges. In addition, the template should instruct nursing homes to send a copy of the notice to the State Ombudsman. Nursing homes could customize the template by including information about the State Ombudsman and other resources in their States.

Require nursing homes to systematically document facility-initiated discharges in information available to CMS and States to enhance oversight

To ensure that nursing homes provide facility-initiated discharge cases for oversight, they must be able to readily identify cases without needing to review individual resident medical records. Additionally, CMS and State survey agencies need to know when these discharges occur to oversee them. CMS should require nursing homes to systematically document facility-initiated discharges at the time of discharge. This should not only increase nursing homes' awareness and compliance but also decrease surveyor workload. CMS could require that nursing homes document these discharges on the Minimum Data Set (MDS), which regularly captures standard assessments and other information on nursing home residents. Currently, CMS requires nursing homes to indicate when they discharge residents on the MDS, but MDS does not distinguish between resident-initiated and facility-initiated discharges or capture the reason for the unplanned discharge category in MDS. If adding this information to MDS is not feasible, CMS should consider other options for nursing homes to systematically document facility-initiated discharges through information available to CMS and States.

Systematically identifying these discharges may also provide opportunities to enhance CMS and State survey agency oversight through targeted review and analytics. For example, if surveyors find that nursing homes are misclassifying these discharges, they can address nursing home noncompliance during the survey. In addition, CMS could use analytics to identify outlier nursing homes that initiate many discharges within a certain time period and alert State agencies for further oversight during surveys.

AGENCY COMMENTS AND OIG RESPONSE

CMS did not explicitly state its concurrence or nonconcurrence for the two recommendations. CMS agreed with the intent of the first recommendation and indicated that it has implemented it, suggesting that it be closed and removed from the report. CMS conveyed disagreement with the second recommendation because it contends it can already identify facility-initiated discharges, also suggesting the recommendation be closed. OIG has considered the actions that CMS has taken and its data on facility-initiated discharges. We have adjusted our first recommendation and stand by our second recommendation.

Initially, the first recommendation was to provide materials, including a standard notice template, and training to help nursing homes accurately identify facility-initiated discharges. CMS stated that it has implemented these actions. Specifically, CMS noted that it updated State Surveyor guidance and provided training in June 2022. In addition, it revised the decision flow chart for State surveyors to evaluate compliance with facility-initiated discharges and provided training in October 2022. We acknowledge that these trainings are intended for both State surveyors and nursing homes and are available publicly on the Quality Safety and Education Portal. Therefore, we have removed this part of the recommendation from the report. However, we do encourage CMS to consider tailoring future training to the specific needs and challenges of nursing homes to help them accurately identify facility-initiated discharges in real time and fulfill requirements. Furthermore, given the scope of noncompliance with notice requirements in our sample, we maintain the value of CMS providing nursing homes with a standard notice template to residents facing discharge. A template will help ensure that nursing homes provide accurate and complete information regarding facility-initiated discharges.

Regarding the second recommendation to require nursing homes to document facility-initiated discharges to enhance oversight, CMS states that it already receives substantially similar data because discharges indicated as "unplanned" in the MDS represent facility-initiated discharges. CMS also noted that asking nursing homes to document the reason for discharge within a resident's medical record and in the MDS would only create an extra burden. Although CMS contends it can identify facility-initiated discharges in the MDS, we disagree with CMS that the existing MDS data are substantially similar to what we are recommending because the "unplanned" indicator in MDS does not reliably identify facility-initiated discharges. First, it captures additional types of discharges. According to the MDS manual, unplanned discharges include discharges beyond those that are facility-initiated discharges, including resident-initiated discharges. For example, an unplanned discharge could represent a resident leaving the nursing home against medical advice or to obtain treatment elsewhere. Second, not all facility-initiated discharges are coded as "unplanned" in the MDS. We identified multiple cases in our sample of facility-initiated discharges in

which the nursing home documented the discharge as "planned" in the MDS. We maintain that CMS and State survey agencies must be able to readily and reliably identify when facility-initiated discharges occur to oversee and enforce the regulations specific to this subset of discharges. Therefore, we continue to support this recommendation, and we encourage CMS to implement it in a way that minimizes the burden for nursing homes.

OIG is committed to protecting the rights, safety, and well-being of nursing home residents and will continue to work with CMS to promote additional actions to achieve that outcome.

For the full text of CMS's comments, see the Appendix.

DETAILED METHODOLOGY

Sample Selection

Ombudsman Selection. After sending an electronic survey to all 51 Ombudsmen and receiving responses from 47 of them, we selected a purposive sample of 13 Ombudsmen that could provide us data on facility-initiated discharge notices. We made this decision based on information that we received from the Ombudsmen regarding how their offices tracked facility-initiated discharge notices. We requested that Ombudsmen from Alabama, Alaska, Idaho, Kansas, Louisiana, Maine, Michigan, Missouri, Montana, Ohio, Rhode Island, Vermont, and Wyoming send us lists of all nursing homes that provided a notice of a facility-initiated discharge from July 1, 2019, through December 31, 2019. We received 820 nursing homes from these Ombudsmen. As of November 2019, 15,471 nursing homes participated in Medicare and/or Medicaid.

Nursing Home Selection. Of the 820 nursing homes, we took a stratified sample of 330 nursing homes to contact. We stratified this sample by State based on the number of nursing homes provided by each State. From the five States with the fewest number of nursing homes provided, we selected all 47 nursing homes reported: 4 from Wyoming, 7 from Rhode Island, 9 from Alaska, 12 from Idaho, and 15 from Montana. From the other eight States, we selected independent simple random samples of nursing homes by State (see Table 1). We allocated the sample sizes based on the number of nursing homes in each State to ensure that States with fewer nursing homes were included in our review. We removed one duplicate observation from our sample and had a final sample of 329 nursing homes.

Table 1: Number of Nursing Homes Selected for Sample

State	Number of nursing homes in sample	Number of nursing homes received from Ombudsmen
Alabama	22	41
Alaska	9	9
Idaho	12	12
Kansas	18	34
Louisiana	26	50
Maine	37	78
Michigan	44	104
Missouri	51	138
Montana	15	15

Ohio	68	299
Rhode Island	7	7
Vermont	17	29
Wyoming	4	4

We sent those 329 nursing homes an electronic survey in which we requested lists of all residents subject to a facility-initiated discharge from July 1, 2019, through December 31, 2019. We received responses from 306 nursing homes, either through the survey or through our followup efforts to contact them by telephone. Ultimately, 130 nursing homes provided a list of residents. Twelve nursing homes had since closed or changed ownership and could not provide any information, and another 23 did not respond. The remaining 164 nursing homes from our sample of 329 told us that they did not initiate any facility-initiated discharges at all during our study's timeframe.

Excluding Ineligible Facility-Initiated Discharge Cases. In total, 130 nursing homes provided 470 initial cases that they identified as facility-initiated discharges. Upon review, we found that hundreds of these did not qualify for this study. In many cases, the resident remained in the facility; others had been temporarily transferred, voluntarily left the facility, or appealed the discharge and stayed in the facility. After our review, we found that just 90 nursing homes provided 156 cases of facility-initiated discharges.

Case File Selection and Preliminary Screening

We contracted health care professionals with expertise in long-term care to conduct the medical record reviews. During our review, we identified and excluded ineligible cases from our study, as described above. The contractors reviewed the medical records for completeness and made additional requests to nursing homes for missing records or information needed for the medical record reviews.

For the 156 cases that we originally identified as facility-initiated discharges, the contractor collected medical record case files. The contractor collected these files from October 2021 through May 2022. In our medical record request, we included a checklist of the specific documentation nursing homes should provide. This included transfer records, physician orders and progress notes, and the facility-initiated discharge notice, among other parts of the medical record. For cases in which the resident was in the nursing home for an extended period of time, we requested that the nursing home provide documentation for the 60 days after the resident's admission date and the 60 days prior to the facility-initiated discharge.

Of the 156 cases that we determined to be actual facility-initiated discharges, the contractor found that an additional 30 were not eligible for this study. The medical records for many of these cases showed that the discharge was initiated on a date outside of our scope. For others, residents entered the facilities for short-term rehabilitation and left voluntarily once their health had improved. For some, the residents or their family members requested release or transfer. And for a few, the contractor was unable to obtain medical documentation of any sort for the resident. This left us with a total of 126 facility-initiated discharge cases in our review.

Medical Record Reviews

We consulted with the contractors to design a structured protocol for the medical record reviews of the facility-initiated discharge cases. We also reviewed CMS regulations and policy documents such as the *State Operations Manual*, Appendix PP: Guidance to Surveyors for Long-Term Care Facilities. The goal of the medical record reviews was to determine whether the nursing home followed Federal regulations for initiating the discharge of a resident. The medical record reviewers followed a structured protocol that OIG developed in consultation with physicians and experts in long-term care.

We developed separate protocols for nurse and physician reviewers. The nurses reviewed all 126 cases of facility-initiated discharges. The physicians reviewed cases when the reason for discharge was clinical and when the nurse reviewers determined the nursing home did not support the reason for discharge or when the nurse reviewers were unable to make a determination. The reasons for facility-initiated discharges that are based on clinical assessments of the resident include: (1) the resident has improved and no longer needs the nursing home's services, (2) the resident's needs cannot be met in the nursing home, (3) the resident endangers the safety of others in the nursing home, and (4) the resident endangers the health of others in the nursing home.

Nurse Reviewer Protocol. The protocol for the nurse reviewers included questions about documentation requirements, support in the medical record for the reason for the discharge, and the resident's clinical status and conditions. Specifically, the protocol asked the nurse reviewers to determine whether the nursing home followed Federal regulations for notifying the resident of the discharge in writing and for documenting the discharge in the medical record. The protocol also included a question about whether the nurse reviewers considered the case to be a facility-initiated discharge, rather than a resident-initiated discharge. Finally, for cases in which the nursing home discharged the resident for a clinical reason, the nurse reviewers determined whether information in the medical record supported this reason

for discharge. The nurse reviewers reviewed the medical records for all 126 cases.

Physician Reviewer Protocol. If the nursing home discharged the resident for a clinical reason and the nurse reviewer determined that the medical record did not support the reason for discharge, or was unable to make a determination, the case then received an additional clinical review by a physician. The physicians reviewed 15 facility-initiated discharge cases. The physician reviewers followed a structured protocol to determine whether the medical record supported the nursing home's reason(s) for discharging the resident. Physicians considered such factors as the resident's condition upon admission, the resident's most recent comprehensive assessment, and the nursing home's attempts at interventions to avoid discharging the resident.

Quality Assurance

To help ensure that reviews were consistent and accurate, we provided a guidance document to both the nurse and physician reviewers on answering questions as they went through the protocol. In addition, the contractors provided trainings to the reviewers. Finally, we held conference calls with reviewers and conducted extensive quality assurance reviews.

Guidance Document. We worked with the nurse and physician reviewers to develop a structured protocol to ensure consistent reviews of the facility-initiated discharge cases. We also provided reviewers with a guidance document that included detailed instructions for each question in the protocol and definitions for important terms. The guidance included a detailed definition of "facility-initiated discharge"; specific documentation to review when assessing compliance with Federal requirements; information to consider when reviewing the reason for discharge; and, in the nurse reviewer protocol, which types of cases should be referred to a physician reviewer.

Training and Pretesting. The medical record review contractor provided training for both the nurse and physician reviewers on the OIG protocols. The training consisted of a review of the guidance documents and an overview of the protocol questions, as well as instructions on how reviewers should enter information into the database. In addition, we conducted pretest reviews for 10 cases with the nurse reviewers to pilot the protocol and provide feedback to the reviewers. We adjusted the protocol based on the results of this pretest.

Consensus Calls. Nurse and physician reviewers participated in separate conference calls to promote consistency across case reviews. During these calls, the reviewers discussed cases with the other nurse or physician reviewers to gain feedback on reviews and reach consensus.

Quality Assurance Reviews. We developed a quality assurance protocol and reviewed nurse and physician protocol responses to ensure that they were following the standardized review protocols when assessing cases. We worked with the medical record review contractor to identify and address inconsistencies across nurse and physician reviews. We also worked with individual nurse and physician reviewers to discuss any questions we had about their protocol responses. Finally, we reviewed the information provided on each facility-initiated discharge case to ensure that the case was eligible to be included in our sample and that the protocol responses accurately reflected the details of the case.

Additional Data

Followup With Ombudsmen. In September and October 2021, we contacted the 13 Ombudsmen from which we obtained our sample and asked them to confirm that they received a facility-initiated discharge notice from the 164 nursing homes that told us they did not initiate any facility-initiated discharges during our study's timeframe. We also interviewed nine of these Ombudsmen to ask about the discrepancies between the information the Ombudsmen and nursing homes provided about the facility-initiated discharges.

Analysis

We analyzed the results of the nurse reviews for the facility-initiated discharge cases within our sample. To determine the extent to which these cases complied with Federal requirements, we examined the nurse review results for questions on whether the cases included a facility-initiated discharge notice and the required information on the notice. We determined the number of cases that did not have a written notice of discharge or did not comply with notice requirements. We also examined the nurse review results for questions on whether the cases followed other documentation requirements in the medical record, such as recording the reason for discharge. Finally, we analyzed the nurse review results for questions about the reason for discharge and whether the nursing home provided support for the reason.

We also analyzed the results of the physician reviews for the 15 facility-initiated discharge cases with a clinical reason for discharge but which the nurse determined the reason was not supported (or was unable to make a determination). We examined the physician review results to determine whether the nursing home supported the reason for discharge.

In addition, we analyzed the open-ended results of the nurse and physician reviews for the facility-initiated discharge cases within our sample. Specifically, we examined the circumstances around the discharge and

Ombudsman involvement. We conducted qualitative analysis and categorized responses by theme to identify patterns across the residents in our sample.

Finally, we analyzed responses from our followup with the Ombudsmen. Specifically, we determined how many nursing homes that told us that they did not initiate a discharge from July 1 through December 31, 2019, did, in fact, send a facility-initiated discharge notice to their Ombudsman during that timeframe. We also examined data from our interviews with nine Ombudsmen to identify potential reasons for this discrepancy and to illustrate challenges Ombudsmen face with receiving these notices.

APPENDIX

Agency Comments

Following this page are the official comments from CMS.

DATE: January 16, 2024

TO: Juliet T. Hodgkins
Principal Deputy Inspector General
Office of Inspector General

FROM: Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General Draft Report: Concerns Remain About Safeguards to Protect Residents During Facility-Initiated Discharges from Nursing Homes (OEI-01-18-00251)

The Centers for Medicare & Medicaid (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report.

CMS is committed to nursing home resident health and safety through enforcement of long-term care (LTC) facilities (referred to in the report as "nursing homes") regulatory requirements, including those to prevent inappropriate resident discharges. Per 42 C.F.R. Part 483, residents have the right to remain in a facility and not be transferred or discharged, except in a limited set of circumstances. The circumstances include when the transfer or discharge is necessary for the resident's welfare or when the resident's needs cannot be met in the facility.[1] Nursing homes must document all facility-initiated discharges in the resident's medical record and provide adequate notice to the resident.[2] Documentation in the resident's medical record must include a discharge care plan and documented discussions with the resident or resident's representative(s) regarding discharge planning and post-discharge care.[3]

Most nursing homes discharge residents safely and appropriately. However, to ensure nursing homes are in compliance with federal requirements, CMS provides ongoing oversight through recertification health and safety surveys conducted by State Survey Agencies (SSAs). In November 2017, CMS revised surveyor interpretive guidance to address discharges that would violate federal requirements. Further, surveyors were directed to investigate fully to determine whether a discharge is compliant and in accordance with the resident and/or their representative.[4] Subsequently, CMS released a survey and certification memorandum, in December 2017,

[1] 42 C.F.R. § 483.15(c)(1)
[2] 42 C.F.R. § 483.15(c)(2)
[3] 42 C.F.R. § 483.21(c)(1)(ix)
[4] Transmittal 173, CMS Manual System, Pub. 100-07 State Operations, Appendix PP - Guidance to Surveyors for Long Term Care Facilities, see guidance for F Tags F622, F623, F660

announcing an initiative to address inappropriate discharges through a number of new actions.[5] The initiative directed SSAs to transfer to CMS any case involving facility-initiated discharge violations when:

- there is a discharge to a questionable or unsafe setting
- residents remain hospitalized (because the nursing home will not permit the resident to return)
- there is a facility pattern of inappropriate discharges
- other circumstances that the SSAs and CMS may identify

Following the review of such cases, CMS may take enforcement action for identified noncompliance, including imposing civil monetary penalties (CMPs) and Denial of Payment for New Admissions, when appropriate. In addition to enforcement, CMS encourages states to use the CMP Reinvestment Program[6] to pursue CMP-funded projects to help prevent improper facility-initiated discharges. Such projects reinvest funds collected from CMPs into initiatives that benefit nursing home residents, which may include those to prevent improper discharges, including for example, projects designed to educate residents and their families on their rights in relation to facility-initiated discharge. CMS also examines SSAs' intake and triage practices for discharge complaints to ensure they are investigated timely, developing examples of inappropriate and appropriate discharges for surveyors, identifying best practices for nursing homes, considering additional training for surveyors, and evaluating enforcement options for these types of violations.

The Office of the State LTC Ombudsman also plays an important role in addressing inappropriate discharges. CMS regulations require facilities to provide immediate access to residents by representatives of the Office of the State LTC Ombudsman.[7] CMS also requires that facilities send a copy of each transfer or discharge notice to the Office of the State LTC Ombudsman.[8] The discharge notice must explain the transfer or discharge and the reason for the move in writing and be supplied to the resident and the resident's representative(s) in a language and manner they understand before the transfer or discharge occurs.[9] Facilities that do not comply with these requirements are subject to deficiency citation and enforcement action.

In June 2022, CMS announced the release of updated guidance and training intended for both SSAs and nursing homes.[10] The updates included clarification of the guidance related to facility-initiated discharges and transfers. For example, CMS clarified that when a facility initiates a discharge while the resident is in the hospital following an emergency transfer (i.e., does not allow the resident to return to the nursing home), the facility must have evidence that the resident's status at the time the resident seeks to return to the facility (not at the time the resident was transferred for acute care) meets one of the discharge criteria at §483.15(c)(i). CMS also clarified guidance to ensure residents and their representatives receive complete and accurate

[5] An Initiative to Address Facility Initiated Discharges that Violate Federal Regulations, Ref: S&C 18-08-NH (Dec. 22, 2017)
[6] CMS Civil Money Penalty Reinvestment Program (CMPRP)
[7] 42 C.F.R. § 483.10(f)(4)(i)
[8] 42 C.F.R § 483.15(c)(3)
[9] 42 C.F.R § 483.15(c)(3)
[10] CMS Revised Long-Term Care Surveyor Guidance, June 29, 2022

information in the notice of transfer and discharge. CMS will continue to work to provide materials and related training to nursing homes and surveyors on this updated guidance.

While CMS appreciates OIG's review it is important to note that this report and OIG's prior report on facility-initiated discharges are based on discharges that took place at least 4 years ago (the most recent discharge included in this review is from 2019).[11] Since then, CMS has made a concerted effort to address inappropriate discharges and has made several updates to the guidance and training requirements. Also, the results are based on a purposive sample representing less than 1% of nursing homes across the country and are not projectable to the entire population.

CMS thanks OIG for its efforts on this important issue and looks forward to working with OIG on this and other issues in the future. OIG's recommendations and CMS's responses are below.

Recommendation (1)
Provide materials, including a standard notice template, and training to help nursing homes accurately identify facility-initiated discharges and fulfill requirements.

CMS Response
CMS agrees with the intent of the recommendation and provided materials and training to help nursing homes accurately identify facility-initiated discharge prior to the issuance of this report, which we've highlighted below. Since the actions have been implemented, CMS suggests OIG consider this recommendation closed. CMS notes that states may have additional notification requirements and resources available, such as through state LTC ombudsman program websites and through the National Long-Term Care Ombudsman Resource Center. As stated above, in June 2022, CMS released updated guidance and training intended for both state survey agencies and nursing homes. CMS will continue to assess our policies for improvements in this area moving forward and will continue to work to provide materials and related training to nursing homes and surveyors on this updated guidance, as appropriate.

CMS notes that the medical records reviewed for this audit were from 2019, prior to the release of the updated guidance and training in June 2022 in which CMS revised the Discharge Critical Element Pathway, a decision flowchart to evaluate compliance with requirements for admission, transfer, and discharge rights, to make a clear distinction between the expectations around facility-initiated and resident-initiated discharges. Training on this guidance was provided, and a revised Discharge Critical Element Pathway (CMS-20132)[12] was rolled out for use on October 22, 2022. The training, which is on the Quality Safety and Education Portal (QSEP), is publicly available for providers. Furthermore, CMS conducted an analysis to identify the root causes of noncompliant discharges, which CMS addressed in the 2022 revisions to Appendix PP of the State Operations Manual. For example, CMS added guidance about residents leaving Against Medical Advice, residents who completed rehab but are not ready for discharge, expectations around discharge for nonpayment, refusal to allow a resident to return from the hospital, and deficiency severity with examples of noncompliance related to discharges pending appeal,

[11] Facility-Initiated Discharges in Nursing Homes Require Further Attention (OEI-01-18-00250)
[12] Discharge Critical Element Pathway: available on the CMS Nursing Homes page under the 'Downloads' section, titled "Survey Resources (ZIP)"

inability to meet a resident's needs, discharge while application for medical assistance is pending, and discharge for behaviors dangerous to others.[13]

Recommendation (2)

Require nursing homes to systematically document facility-initiated discharges in information available to CMS and States to enhance oversight.

CMS Response

Based on the information below, CMS suggests OIG consider this recommendation closed. The regulations do not compel nursing homes to maintain or produce a list of facility-initiated discharges. This would also be a highly resource-intensive effort. Collecting data from discharge notices does not identify non-compliant facility-initiated discharge because, with these requirements, it is necessary to review the facts of each discharge case individually to determine compliance.

Additionally, it is important to note that CMS already receives substantially similar data on discharges from the Minimum Data Set (MDS) submissions. When onsite for a survey, surveyors review randomly selected discharges in MDS coded as "unplanned." These "unplanned" discharges represent facility-initiated discharges, whereas "planned" discharges represent discharges that are part of the resident's goals that they've agreed to and for which they've planned.

OIG's recommendation states that the MDS does not distinguish between resident-initiated and facility-initiated discharges. However, as stated above, the MDS does already distinguish between planned and unplanned discharges, which are investigated for compliance. Requiring nursing homes to systematically document facility-initiated discharges in the MDS would not improve CMS's ability to oversee discharges, as both facility or resident-initiated discharges can be compliant or noncompliant discharges. For unplanned discharges, CMS already requires documentation in the resident's medical records, and asking facilities to document the reason for the unplanned discharge in MDS would only create an extra burden for providers. Further, surveyors are directed to review randomly selected unplanned discharge cases, and surveyors are also aware of a facility's past non-compliance. While reviewing facility-initiated discharge cases, if a surveyor finds that a nursing home was misclassifying discharges, surveyors address the issue onsite and follow up as necessary.

[13] CMS State Operations Manual, Appendix PP, F-tag 622, pages 185, 187, 190

ACKNOWLEDGMENTS AND CONTACT

Acknowledgments

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This report was prepared under the direction of Joyce Greenleaf, Regional Inspector General for Evaluation and Inspections in the Boston Regional Office, and Danielle Fletcher, Deputy Regional Inspector General.

Contact

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Office of Inspector General
Department of Health and Human Services
330 Independence Avenue, SW
Washington, DC 20201

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ENDNOTES

[1] Silver-Greenburg, Jessica and Harris, Amy Julia, "'They Just Dumped Him Like Trash': Nursing Homes Evict Vulnerable Residents," *The New York Times*, June 21, 2020. Accessed at https://www.nytimes.com/2020/06/21/business/nursing-homes-evictions-discharges-coronavirus.html on Jan. 5, 2023.

[2] Jaffe, Ina, "As Nursing Homes Evict Patients, States Question Motives," *NPR,* May 26, 2017. Accessed at https://www.npr.org/sections/health-shots/2017/05/26/529915765/states-try-to-keep-nursing-homes-from-kicking-out-less-lucrative-patients on Jan. 5, 2023.

[3] 42 CFR § 483.15(c); CMS, *State Operations Manual*, Appendix PP–Guidance to Surveyors for Long-Term Care Facilities (Rev. Oct. 26, 2022), Tag 622.

[4] CMS, *State Operations Manual*, Appendix PP–Guidance to Surveyors for Long-Term Care Facilities (Rev. Oct. 26, 2022), Tag 622.

[5] 81 Fed. Reg. 68688, 68730 (Oct. 4, 2016).

[6] 42 CFR §§ 483.15(c)(2) and (3)(ii).

[7] When the nursing home discharges a resident because it cannot meet the resident's needs or the resident no longer needs the nursing home's services, the resident's physician must document the reason for discharge. In cases in which the nursing home discharges the resident because the safety or health of others in the facility are endangered, any physician can document the reason for discharge (see 42 CFR § 483.15(c)(2)(i)-(ii)).

[8] 42 CFR § 483.15(c)(2)(i)(B).

[9] CMS, *State Operations Manual*, Appendix PP–Guidance to Surveyors for Long-Term Care Facilities (Rev. Oct. 26, 2022), Tag 622.

[10] CMS, *State Operations Manual*, Appendix PP–Guidance to Surveyors for Long-Term Care Facilities (Rev. Feb. 3, 2023), Tag 623.

[11] 42 CFR § 483.15(c)(3)(i).

[12] Administration for Community Living, Older Americans Act. Accessed at https://acl.gov/about-acl/authorizing-statutes/older-americans-act on Mar. 10, 2023.

[13] CMS, *State Operations Manual*, Appendix PP–Guidance to Surveyors for Long-Term Care Facilities (Rev. Oct. 26, 2022), Tag 623.

[14] For residents with intellectual and developmental disabilities and for residents with a mental disorder or related disabilities, nursing homes must include the mailing and email address and telephone number of the agency responsible for the protection and advocacy of these residents on the facility-initiated discharge notice (see 42 CFR § 483.15(c)(5)).

[15] 42 CFR § 483.15(c)(6).

[16] CMS, *State Operations Manual*, Appendix PP–Guidance to Surveyors for Long-Term Care Facilities (Rev. Oct. 26, 2022), Tag 623.

[17] 42 CFR § 483.15(c)(4).

[18] 42 CFR § 431.220(a)(2).

[19] 42 CFR § 483.15(c)(1)(ii).

[20] *CMS Should Take Further Action To Address States With Poor Performance in Conducting Nursing Home Surveys* (OEI-06-19-00460) Jan. 14, 2022.

[21] *Onsite Surveys of Nursing Homes During the COVID-19 Pandemic: March 23-May 30, 2020* (OEI-01-20-00430) Dec. 17, 2020.

[22] *Some Nursing Homes' Reported Staffing Levels in 2018 Raise Concerns; Consumer Transparency Could Be Increased* (OEI-04-18-00450) Aug. 3, 2020.

[23] *States Continued To Fall Short in Meeting Required Timeframes for Investigating Nursing Home Complaints: 2016-2018* (OEI-01-19-00421) Sept. 22, 2020.

[24] *Facility-Initiated Discharges in Nursing Homes Require Further Attention* (OEI-01-18-00250) Nov. 18, 2021.

[25] *Nursing Home Residents with Mental Health Disorders and Behaviors May be Vulnerable to Facility-Initiated Discharges* (OEI-01-18-00252) Mar. 2024.

[26] Of the 344 excluded cases, 330 cases were not a facility-initiated discharge (i.e., the resident initiated the discharge or remained in the facility), 10 cases were outside of the study time period, and 4 cases lacked enough documentation to review.

[27] Twenty-three nursing homes did not respond to our request, and 12 nursing homes closed or changed ownership and could not provide the medical records. We made repeated attempts to contact the 23 nursing homes that did not response to our request.

[28] 81 Fed. Reg. 68688, 68730 (Oct. 4, 2016).

[29] Surveyors use Minimum Data Set assessment data to select one resident who experienced an unplanned discharge.