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MEMORANDUM

TO: The Task Force to Study the Process for Bringing Criminal Cases in Situations of Violence Against Health Care Workers
FROM: Department of Health and Human Services
DATE: September 6, 2022
RE: Responding to Questions from the Task Force

Below please find information from the Department of Health and Human Services (DHHS) in response to questions received from the Task Force.

1. What are the legal requirements of residential facilities to allow residents to return to their home after a hospital visit?

The regulatory requirements for nursing facilities and assisted housing facilities (assisted living, residential care facilities, and PNMIs) are copied below for reference. Essentially, a facility that sends a resident to an acute care hospital must allow the resident to return to the facility unless the resident has exceeded the bed hold requirements or met criteria for a facility-initiated emergency discharge. A facility can initiate an emergency discharge if the resident is a danger to themself or others within the facility consistent with 5.5 of the 10-144 CMR Ch 113, Regulations Governing the Licensing and Functioning of Assisted Housing Programs or 42 CFR§483.15(c) of the CMS Nursing Home Regulations.

The relevant provision for an Assisted Housing program is:

> **5.5 Emergency transfer or discharge**. When an emergency situation exists, no written notice is required, but such notice as is practical under the circumstance shall be given to the consumer and/or consumer's representative. The assisted living program shall assist the consumer and authorized representatives in locating an appropriate placement. Transfer to an acute hospital is not considered a placement and the obligation in regard to such assistance does not necessarily terminate. *[Class IV]*

The relevant Nursing Facility federal regulation is:

> **42 CFR 483.15 (c) Transfer and discharge -** The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—
>
> > (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;

(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;

All PNMI Appendix E providers are licensed as assisted housing facilities and would fall under the same rule provisions for an emergency transfer or discharge that is noted above. In addition to emergency transfer or discharge, Appendix E providers are also required to follow 10-144 Chapter 101 MaineCare Benefits Manual, Chapter II Section 97.07.10 T

97.07-10 **Termination**

For members receiving Appendix E services under this Section, providers must:

A. Obtain written approval from the Director of the Office of Behavioral Health (OBH) or designee prior to terminating services to that member;
B. If approved by OBH, issue a thirty (30) day advanced written termination notice to the member prior to termination of the member's services. In cases where the member poses a threat of imminent harm to persons employed or served by the provider, the Director of OBH may approve a shorter notification for termination of services; and
C. Assist the member in obtaining clinically necessary services from another provider prior to discharge or termination.

2. What prevents a facility from taking a resident to an ER when a hospital would determine that there is not actually a medical emergency?

For assisted housing, there is no policy that prevents this as assisted housing facilities do not have medical staff on site 24/7 to assess a resident for a medical emergency. Nursing facilities do have nurses who conduct assessments and consult with the resident's physician or covering medical provider; however, if the resident or guardian insists on going to the hospital and the resident has not been deemed incompetent to make medical decisions, then the facility must send them to the hospital (nursing facilities are still required to consult with the resident's physician or covering medical provider before sending the resident to the hospital).

OBH has contract provisions with PNMI E providers requiring program staff to accompany clients to the ER as outlined in Rider A, Scope of Work, Deliverables Section B Provider Staffing: Position Types, Qualifications and Hiring/ Retention Standards:

3. Ensure that if a client receiving services under this Agreement presents at an emergency room, PNMI staff must accompany the client through the MaineCare/ OBH PNMI Covered Service day/night. The staff member shall stay at the emergency room with the client until midnight of the Covered Service day/night unless there is a court order stating otherwise.

a. In the event that a crisis team or the hospital determine that there is no need for Provider to remain with the client, the Provider shall communicate contact information to hospital staff for discharge planning.

In addition to accompanying all clients to the Emergency Department, PNMIs must submit Critical Incident Reports to the Department for review when they occur. Critical incidents, are categorized as level one or level two, which are defined as follows:

> Level 1: Are those that result in death or serious injury and/or significantly jeopardize clients, public safety or program integrity. Such incidents involving clients must be reported to OBH regardless of the location of the incident. A client's death is always reported as a Level I, regardless of whether the death was attended or not and regardless of the cause of death.
>
> Level 2: Are those that include significant errors or undesirable events that compromise the quality of care or client safety.

Each Critical Incident Report is reviewed timely by an OBH PNMI staff member. Consultation is provided to the hospital and PNMI facilities by OBH staff throughout the incident and afterward to ensure clients are placed safely in an appropriate facility and mitigate future incidents.

3. How are these requirements enforced?

A resident or guardian may appeal the discharge from the PNMI or refusal of the PNMI to take the resident back from a hospital. Such an appeal is sent to a hearings officer for review. A facility is required to allow the resident to remain in the facility and/or hold a space for the resident pending appeal. Facilities that are not in compliance are issued a citation of noncompliance. If they fail to submit an acceptable plan of correction, then they are issued a directed plan of correction. If a facility appeals the enforcement action, then it is referred to an appeal hearing or in some cases can go to an Informal Dispute Resolution (IDR) process before going to an appeal hearing. The Division of Licensing and Certification (DLC) is not able to take enforcement action while an appeal is pending. If the facility is federally certified, CMS may take enforcement action consistent with Chapter 7 of the CMS State Operations Manual for Long Term Care.

4. What is the role of crisis teams, including in the hospital system, to ensure that residents are able to return to their facilities?

DHHS has implemented a crisis continuum of care that is inclusive of Mobile Crisis and Crisis Residential Services. These crisis services are available to support individuals in residential settings. Mobile Crisis Teams can be utilized proactively to respond and intervene early to prevent individuals from needing to access the Emergency Department and further Mobile Crisis Teams can respond and support after an individual has returned to their program from an Emergency Department setting. The Office of Child and Family Services (OCFS) also provides

aftercare mobile services that can follow up with PNMI programs for consultation and safety planning.

Mobile Crisis Services

OBH has 7 agencies contracted to provide community-based crisis services. Each contracted provider is required to provide effective Mobile Services and Crisis Residential services in the least restrictive setting and connect persons in crisis to community-based service providers. Contracted providers are required to do the following:

1. Provide twenty-four (24) hours per day, seven (7) days per week, three-hundred and sixty-five (365) days per year immediate, on-scene, face-to-face interventions, with approval by the Statewide Crisis Telephone Response.
2. Maintain at a minimum, at the Mobile Services business office location, business operating hours from Monday to Friday, eight (8) a.m. to five (5) p.m.
3. Comply with the Rights of Recipients of Mental Health Services, as stated in 14-193 C.M.R. ch. 1, throughout the entire Agreement period.
4. Comply with the Rights of Recipients of Mental Health Services Who are Children in Need of Treatment, as stated in 14-472 C.M.R. ch. 1, throughout the entire Agreement period.
5. Mobile Services may be provided via telehealth if all guidelines are followed (10-144 Ch. 1, Section 4):
    a. Client must be provided the opportunity to choose the location of the assessment and how it is delivered. If client chooses not to receive telehealth, then Provider must deliver a Face-to-Face assessment.
    b. Mobile Services delivered via Telehealth shall be of comparable quality to what it would be if it were delivered in-person.

Mobile Crisis service provisions are noted within the MaineCare Benefits Manual Chapter II Section 65, cited below:

65.06 COVERED SERVICES

65.06-1 Crisis Resolution Services

Services are immediate crisis-oriented services provided to a member with a serious problem of disturbed thought, behavior, mood or social relationships, and/or crises originating from problems associated with an intellectual disability, autism, or other related condition. Services are oriented toward the amelioration and stabilization of these acute emotional disturbances to ensure the safety of a member or society and can be provided in an office or on scene. "On scene" can mean a variety of locations including member homes**,** school, street, emergency shelter, and emergency rooms.

Services include all components of screening, assessment, evaluation, intervention, and disposition commonly considered appropriate to the provision of emergency and crisis mental health

care, to include co-occurring mental health and substance abuse conditions. Crisis Resolution Services are individualized therapeutic intervention services available on a twenty-four (24) hour, seven (7) day a week basis and provided to eligible members by providers that have a contract with DHHS to provide these services.

Covered services include direct telephone contacts with both the member and the member's parent or guardian or adult's member's guardian when at least one face-to-face contact is made with the member within seven (7) days prior to the first contact related to the crisis resolution service. The substance of the telephone contact(s) must be such that the member is the focus of the service, and the need for communication with the parent or guardian without the member present must be documented in the member's record.

Staff providing Crisis Services must have an MHRT (Mental Health Rehabilitation Technician) Certification at the level appropriate for the services being delivered. Supervisors of MHRT staff must be clinicians as defined in 65.02-11, within the scope of their licensure.

A treatment episode is limited to six (6) face-to-face visits and related follow up phone calls over a thirty (30) day period after the first face to face visit.

Crisis Residential Service

As part of the Crisis Service continuum Crisis Residential programs and the Cumberland County Crisis Receiving Center can also be utilized for crisis assessment and stabilization services and programming. The seven agencies that provide Mobile Crisis Services also provide Crisis Residential Services. The Crisis Residential services provisions are noted within the MaineCare Benefits Manual Chapter II Section 65, cited below:

65.06 COVERED SERVICES

65.06-2 **Crisis Residential Services**

Crisis Residential Services are individualized therapeutic interventions provided to a member during a psychiatric emergency, and/or crises originating from problems associated with an intellectual disability, autism, or other related condition to address mental health and/or co-occurring mental health and substance abuse conditions for a time-limited post-crisis period, in order to stabilize the member's condition. These services may be provided in the member's home or in a temporary out-of-home setting and include the development of a crisis stabilization plan. Components of crisis residential services include assessment; monitoring behavior and the member's response to therapeutic interventions; participating and assisting in planning for and

> implementing crisis and post-crisis stabilization activities; and supervising the member to assure personal safety. Services include all components of screening, assessment, evaluation, intervention, and disposition commonly considered appropriate to the provision of emergency and crisis mental health care.
>
> Staff providing Crisis Services for adults with mental health as a primary condition must have an MHRT (Mental Health Rehabilitation Technician) Certification at the level appropriate for the services being delivered. Staff
> providing Crisis Services for adults with intellectual disability, autism, or other related conditions must hold a current Direct Support Professional certification. Supervisors of MHRT staff must be a clinician, as defined in 65.02-11, practicing within the scope of their licensure.
>
> For children's Crisis Residential Services determination of the appropriate level of care shall be based on tools approved by DHHS and clinical assessment information obtained from the member and family.

Providers are encouraged to work collaboratively with emergency departments and other providers for assessment, referral and other follow up services. Accessing these services can be done so by calling the Maine Crisis Line at 988 or 1-888-568-1112.

5. What other services are provided to the hospital and/or the resident to convince the residential program (or a different program/home) to take a resident with behavioral or violent issues?

DLC has a limited role in these situations and would make a referral to the Maine Long Term Care Ombudsman Program for advocacy and mediation.

Please see the response to Question 6 below related to additional services provided to facilities to support the successful placement, treatment, and recovery of individuals who present with complex needs and behaviors due to their behavioral health conditions.

6. What services are provided to any or all of these facilities to help manage violent residents?

There are several ways in which PNMI E providers receive assistance to support the successful treatment and engagement of individuals with complex treatment needs in residential program facilities. This assistance can come in form of training and clinical consultation to providers in developing an appropriate individualized care plan or referrals for further adjunct services. Adjunct services could include OADS services, additional therapies, specific case management,

etc. OBH can waive the duplication of services issues when additonal concurrent services are needed.

Further, on occasion increased staffing is authorized particularly in the behavioral stabilization phase of an admission to a new facility. For challenging and more complex cases for which a PNMI may not be the right fit, a referral can be made to the Complex Case Unit (CCU). Referral to the CCU can be found online here.

Facilities are also expected to screen potential residents at admission to ensure that once these individuals are admitted to a facility, the facility is able to meet the residents' needs to ensure they reach or maintain their highest level of functioning and that the facility can adequately manage the client with the level of care available. Additionally, PNMI staff qualifications require all direct care staff to be certified as a Mental Health Rehab Technician 1 (MHRT1), which requires participation in a Department-approved behavioral intervention program and the Mental Health Support Specialist Training to assure they have the skill set to work with adults with serious and persistent mental health issues. Providers are required to implement an approved de-escalation training to all staff and to provide an annual refresher training as part of their licensing requirements.

Appendix A: Relevant Regulatory Rules and Guidance:

CMS Nursing Home Involuntary Discharge:
F622 (Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)
§483.15(c) Transfer and discharge-
§483.15(c)(1) Facility requirements-

(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—

(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.

(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.

(i) Documentation in the resident's medical record must include:

(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).

(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by—

(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and

(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.

(iii) Information provided to the receiving provider must include a minimum of the following:

(A) Contact information of the practitioner responsible for the care of the resident.

(B) Resident representative information including contact information

(C) Advance Directive information

(D) All special instructions or precautions for ongoing care, as appropriate.

(E) Comprehensive care plan goals;

(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.

INTENT

To specify the limited conditions under which a skilled nursing facility or nursing facility may initiate transfer or discharge of a resident, the documentation that must be included in the medical record, and who is responsible for making the documentation. Additionally, these requirements specify the information that must be conveyed to the receiving provider for residents being transferred or discharged to another healthcare setting.

DEFINITIONS

"Facility-initiated transfer or discharge": *A transfer or discharge which the resident objects to, 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.*

"Resident-initiated transfer or discharge": *Means the resident or, if appropriate, the resident representative has provided verbal or written notice of intent to leave the facility (leaving the facility does not include the general expression of a desire to return home or the elopement of residents with cognitive impairment).*

"Transfer and Discharge": *Includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility. Specifically, transfer refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility when the resident expects to return to the original facility. Discharge refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility or other location in the community, when return to the original facility is not expected.*

GUIDANCE

NOTE*: The provisions at §483.15(c) (1) and (2) (i)-(ii), only apply to transfers or discharges that are initiated by the facility, not by the resident. Section §483.15(c) (2) (iii) applies to both facility and resident initiated transfers (for information required at discharge, refer to F661, Discharge Summary).*

These regulations limit the circumstances under which a facility can initiate a transfer or discharge, thus protecting nursing home residents from involuntary discharge.
In the following limited circumstances, facilities may initiate transfers or discharges:

1. The discharge or transfer is necessary for the resident's welfare and the facility cannot meet the resident's needs.
2. The resident's health has improved sufficiently so that the resident no longer needs the care and/or services of the facility.
3. The resident's clinical or behavioral status (or condition) endangers the safety of individuals in the facility.
4. The resident's clinical or behavioral status (or condition) otherwise endangers the health of individuals in the facility.
5. The resident has failed, after reasonable and appropriate notice to pay, or have paid under Medicare or Medicaid, for his or her stay at the facility.
6. The facility ceases to operate.

Surveyors must ensure that for discharges related to circumstances 1, 3, or 4 above, the facility has fully evaluated the resident, and does not base the discharge on the resident's status at the time of transfer to the acute care facility. See additional guidance at F626, §483.15(e) (1), Permitting Residents to Return. Facility-initiated transfers and discharges must meet all transfer and discharge requirements at §483.15(c) (1) - (5).

Section §483.15(c) (1) (i) provides that "The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless…." This means that once admitted, for most residents (other than short-stay rehabilitation residents) the facility becomes the resident's home. Facilities are required to determine their capacity and capability to care for the residents they admit. Therefore, facilities should not admit residents whose needs they cannot meet based on the Facility Assessment. (See F838, Facility Assessment). There may be rare situations, such as when a crime has occurred, that a facility initiates a discharge immediately, with no expectation of the resident's return.

Resident-initiated transfers or discharges occur when the resident or, if appropriate, his/her representative has given written or verbal notice of their intent to leave the facility. A resident's expression of a general desire or goal to return to home or to the community or the elopement of a resident who is cognitively-impaired should not be taken as a notice of intent to leave the facility.
Discharges following completion of skilled rehabilitation may not always be a resident-initiated discharge. In cases where the resident may not object to the discharge, or has not appealed it, the discharge could still be involuntary and must meet all requirements of this regulation.

Surveyors must determine whether a transfer or discharge is resident or facility-initiated. The medical record should contain documentation or evidence of the resident's or resident representative's verbal or written notice of intent to leave the facility, a discharge care plan, and documented discussions with the resident or, if appropriate, his/her representative, containing details of discharge planning and arrangements for post-discharge care (See F660, Discharge Planning Process, and F661, Discharge Summary). Additionally, the comprehensive care plan should contain the resident's goals for admission and desired outcomes, which should be in alignment with the discharge if it is resident-initiated.

If a surveyor has concerns about whether a resident-initiated transfer or discharge was actually a facility-initiated transfer or discharge, the surveyor should investigate further through interviews and record review.

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

If transfer is due to a significant change in the resident's condition, but not an emergency requiring an immediate transfer, then prior to any action, the facility must conduct and document the appropriate assessment to determine if revisions to the care plan would allow the facility to meet the resident's needs. (See §483.20(b) (2) (ii), F637 for information concerning assessment upon significant change.)

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

Nonpayment as Basis for Discharge
Non-payment for a stay in the facility occurs when:

- *The resident has not submitted the necessary paperwork for third party (including Medicare/Medicaid) payment; or*
- *After the third party payor denied the claim and the resident refused to pay.*

It is the responsibility of the facility to notify the resident of their change in payment status, and the facility should ensure the resident has the necessary assistance to submit any third party paperwork. In situations where a resident representative has failed to pay, the facility may discharge the resident for nonpayment; however, if there is evidence of exploitation or misappropriation of the resident's funds by the representative, the facility should take steps to notify the appropriate authorities on the resident's behalf, before discharging the resident.

For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid. Additionally, conversion from a private pay rate to payment at the Medicaid rate does not constitute non-payment.

Emergent Transfers to Acute Care
Residents who are sent emergently to the hospital are considered facility-initiated transfers because the resident's return is generally expected.

*Residents who are sent to the emergency room, **must** be permitted to return to the facility, unless the resident meets one of the criteria under which the facility can initiate discharge. In a situation where the facility initiates discharge while the resident is in the hospital following*

emergency transfer, the facility must have evidence that the resident's status is not based on his or her condition at the time of transfer) meets one of the criteria at §483.15(c)(i)(A) through (D).

483.15(c)(1)(ii) Discharge pending appeal

When a resident chooses to appeal his or her discharge from the facility, the facility may not discharge the resident while the appeal is pending. Additionally, if a resident's initial Medicaid application is denied but appealed, the resident is not considered to be in nonpayment status. Thus, an appeal suspends a finding of nonpayment. Appeal procedures vary by State.

If the resident, or if applicable, their representative, appeals his or her discharge while in a hospital, facilities must allow the resident to return pending their appeal, unless there is evidence that the facility cannot meet the resident's needs, or the resident's return would pose a danger to the health or safety of the resident or others in the facility. If there are concerns related to a facility's determination that it cannot meet a resident's needs, surveyors should assess whether the facility has admitted residents with similar needs. A facility's determination to not permit a resident to return while an appeal of the resident's discharge is pending must not be based on the resident's condition when originally transferred to the hospital.

Required Documentation

To demonstrate that any of the circumstances permissible for a facility to initiate a transfer or discharge as specified in 1 – 6 above have occurred, the medical record must show documentation of the basis for transfer or discharge. This documentation must be made before, or as close as possible to, the actual time of transfer or discharge.

*For circumstances 1 and 2 above for permissible facility-initiated transfer or discharge, the **resident's physician** must document information about the basis for the transfer or discharge. Additionally, for circumstance 1 above, the inability to meet the resident's needs, the documentation made by the **resident's physician must** include:*

- *The specific resident needs the facility could not meet;*
- *The facility efforts to meet those needs; and*
- *The specific services the receiving facility will provide to meet the needs of the resident which cannot be met at the current facility.*

In circumstances 3 and 4 above, documentation regarding the reason for the transfer or discharge must be provided by a physician, not necessarily the attending physician.

***NOTE**: Documentation of the transfer or discharge may be completed by a non-physician practitioner (NPP) in accordance with State law.*

Information Conveyed to Receiving Provider

The regulations at §483.15(c)(2)(iii) address information that must be conveyed to the receiving provider when a resident is transferred or discharged. The specific information which must be conveyed depends upon whether the resident is transferred (expected to return), or is discharged (not expected to return). If the resident is being transferred, and return is expected, the following information must be conveyed to the receiving provider:

- *Contact information of the practitioner who was responsible for the care of the resident;*
- *Resident representative information, including contact information;*
- *Advance directive information;*
- *Special instructions and/or precautions for ongoing care, as appropriate, which must include, if applicable, but are not limited to:* o *Treatments and devices (oxygen, implants, IVs, tubes/catheters);*
    - *Precautions such as isolation or contact;*
    - *Special risks such as risk for falls, elopement, bleeding, or pressure injury and/or aspiration precautions;*
- *The resident's comprehensive care plan goals; and*
    - *All information necessary to meet the resident's needs, which includes, but may not be limited to:*
        - *Resident status, including baseline and current mental, behavioral, and functional status, reason for transfer, recent vital signs;*
        - *Diagnoses and allergies;*
        - *Medications (including when last received); and*
        - *Most recent relevant labs, other diagnostic tests, and recent immunizations.*
- *Additional information, if any, outlined in the transfer agreement with the acute care provider (See §483.70(j) for additional information).*

***NOTE**: It may not be possible to convey all care plan information prior to urgent transfers, however, this information must be conveyed as close as possible to the actual time of transfer. For residents being discharged (return not expected), the facility must convey all of the information listed above, along with required information found at §483.21(c)(2) Discharge Summary, F661. Communicating this information to the receiving provider is one way the facility can reduce the risk of complications and adverse events during the resident's transition to a new setting.*

Facilities may choose their own method of communicating transfer or discharge information, such as a universal transfer form or an electronic health record summary, as long as the method contains the required elements. The transferring or discharging facility may transmit the information electronically in a secure manner which protects the resident's privacy, as long as the receiving facility has the capacity to receive and use the information. Communication of this required information should occur as close as possible to the time of transfer or discharge.

INVESTIGATIVE PROTOCOL
Use the Critical Element (CE) Pathways for Community Discharge, or Hospitalization, as appropriate, along with the above interpretive guidelines when determining if the facility meets the requirements for, or investigating concerns related to the facility transfer or discharge requirements.

Summary of Investigative Procedure
Briefly review the most recent comprehensive assessment, comprehensive care plan, progress notes, and orders to identify the basis for the transfer or discharge; during this review, identify

the extent to which the facility has developed and implemented interventions to avoid transferring or discharging the resident, in accordance with the resident's needs, goals for care and professional standards of practice. This information will guide observations and interviews to be made in order to corroborate concerns identified. ***NOTE****: Always observe for visual cues of psychosocial distress and harm (see Appendix P, Guidance on Severity and Scope Levels and Psychosocial Outcome Severity Guide).*

Assisted Housing Rules 10-144 Chapter 113:

5.3 **Rights regarding transfer and discharge**. Each consumer has the right to continued residence whenever a valid contract for services is in force. The assisted living program must show documented evidence of strategies used to prevent involuntary transfers or discharges. A consumer shall not be transferred or discharged involuntarily, except for the following reasons:

5.3.1 When there is documented evidence that a consumer has violated the admission contract obligations, despite reasonable attempts at problem resolution; *[Class IV]*

5.3.2 A consumer's continued tenancy constitutes a direct threat to the health or safety of others; *[Class IV]*

5.3.3 A consumer's intentional behavior has resulted in substantial physical damage to the property of the assisted living program or others residing in or working there; *[Class IV]*

5.3.4 A consumer has not paid for his/her services in accordance with the contract between the assisted living program and the consumer; *[Class IV]*

5.3.5 When there is documented evidence that the assisted living program cannot meet the needs of the consumer as the program is fundamentally designed; *[Class IV]* or

5.3.6 The license has been revoked, not renewed, or voluntarily surrendered. *[Class IV]*

5.4 **Transfer or discharge**. When a consumer is transferred or discharged in a non-emergency situation, the consumer or his/her guardian shall be provided with at least fifteen (15) days advance written notice to ensure adequate time to find an alternative placement that is safe and appropriate. The provider has an affirmative responsibility to assist in the transfer or discharge process and to produce a safe and orderly discharge plan. If no discharge plan is possible, then no involuntary non-emergency discharge shall occur until a safe discharge plan is in place. Appropriate information, including copies of pertinent records, shall be transferred with a consumer to a new placement. *[Class IV]* Each notice must be written and include the following:

5.4.1 The reason for the transfer or discharge, including events which are the basis for such action; *[Class IV]*

5.4.2 The effective date of the transfer or discharge; *[Class IV]*

5.4.3 Notice of the consumer's right to appeal the transfer or discharge as set forth in Section 5.28; *[Class IV]*

5.4.4 The mailing address and toll-free telephone number of the Long Term Care Ombudsman Program; *[Class IV]*

5.4.5 In the case of consumers with developmental disabilities or mental illness, the mailing address and telephone number of the Office of Advocacy, Department of Health and Human Services (formerly known as the Department of Behavioral and Developmental Services (BDS)); *[Class IV]*

5.4.6 The consumer's right to be represented by himself/herself or by legal counsel, a relative, friend, or other spokesperson. *[Class IV]*

5.5 Emergency transfer or discharge. When an emergency situation exists, no written notice is required, but such notice as is practical under the circumstance shall be given to the consumer and/or consumer's representative. The assisted living program shall assist the consumer and authorized representatives in locating an appropriate placement. Transfer to an acute hospital is not considered a placement and the obligation in regard to such assistance does not necessarily terminate. *[Class IV]*

5.6 Leaves of absence. When a consumer is away, and continues to pay for services in accordance with the contract, the consumer shall be permitted to return unless any of the reasons set forth in Section 5.3 are present and the consumer or consumer's legal representative has been given notice as may be required in these regulations. *[Class IV]*

5.7 Assistance in finding alternative placement. Consumers who choose to relocate shall be offered assistance in doing so.

5.7.1 Assisted living programs may require up to a fifteen (15) calendar day notice for consumers choosing to relocate in order to obtain a refund. For those consumers who relocate for emergency medical treatment no advance notice is required to obtain a refund.

5.7.2 The assisted living program shall offer information to the consumer, as appropriate, regarding potential risks that may be inherent in the discharge plan and information that will support the consumer's adjustment to his/her next setting. [Class IV]

5.28 Right to appeal an involuntary transfer or discharge. The resident has the right to an expedited administrative hearing to appeal an involuntary transfer or discharge. A resident may not appeal a discharge due to the impending closure of the program unless he/she believes the transfer or discharge is not safe or appropriate. To file an appeal regarding an involuntary transfer or discharge, the resident must submit the appeal within five (5) calendar days of receipt of a written notice. If the resident has already been discharged on an emergency basis, the provider shall hold a space available for the resident pending receipt of an administrative decision. Requests for appeals shall be submitted to the Assistant Director of the Division of Licensing and Certification, Community Services Programs for submission to the Office of Administrative Hearings, 11 State House Station, Augusta, Maine 04333-0011. The provider is responsible for defending its decision to transfer or discharge the resident at the administrative hearing. *[Class IV]*