U.S. Department of Health and Human Services

Office of Inspector General

Facility-Initiated Discharges in Nursing Homes Require Further Attention

Christi A. Grimm
Principal Deputy Inspector General
November 2021, OEI-01-18-00250

U.S. Department of Health and Human Services

Office of Inspector General

Report in Brief

November 2021, OEI-01-18-00250

Facility-Initiated Discharges in Nursing Homes Require Further Attention

Key Takeaway

The magnitude of facility-initiated discharges in nursing homes is unknown, and the safeguards to protect residents from inappropriate facility-initiated discharges need improvement.

Why OIG Did This Review

Nursing homes can legally discharge residents for certain reasons (known as facility-initiated discharges). Facility-initiated discharges that do not comply with regulations (i.e., inappropriate facility-initiated discharges) can be unsafe and a traumatic experience for the resident; media reports have highlighted the rise in these discharges. For example, the police found one resident on the streets after a nursing home discharged him to an unlicensed boarding house without notifying his family. In addition, State Ombudsmen have cited "discharge/eviction" as the top complaint from 2013 through 2019. Given concerns about inappropriate facility-initiated discharges and the risk to vulnerable nursing home residents, efforts to reduce these discharges warrant our examination.

How OIG Did This Review

We surveyed State Ombudsmen in all 50 States and the District of Columbia. We also analyzed Centers for Medicare & Medicaid Services (CMS) administrative data to determine the number of nursing homes that received a deficiency related to facility-initiated discharge. We interviewed officials in the Administration for Community Living (ACL), CMS, and all 10 CMS Regional Offices (ROs) about efforts to reduce inappropriate facility-initiated discharges. We also interviewed five State Ombudsmen about the effect of COVID-19 on these discharges.

Federal regulations allow nursing homes to discharge residents without their consent for a specific set of reasons and detail additional requirements for these discharges, such as the nursing home providing adequate notice to the resident. CMS oversees nursing homes and works with State survey agencies (State agencies) to monitor compliance with facility-initiated discharge regulations. ACL oversees the State Long-Term Care Ombudsman Program (State Ombudsmen), which advocates on behalf of nursing home residents to resolve complaints made by or for these residents. In 2017, CMS instructed State agencies to transfer certain cases of noncompliance with facility-initiated discharge regulations to CMS ROs for potential enforcement action, as part of an initiative to review and take appropriate enforcement action in these cases.

What OIG Found

The magnitude of facility-initiated discharges in nursing homes remains unknown. Many challenges exist to identifying and addressing inappropriate facility-initiated discharges, including that neither ACL nor CMS collect data on the number of facility-initiated discharges, and many State Ombudsmen do not count or track the notices they receive. Nursing homes must send facility-initiated discharge notices to State Ombudsmen, but ACL does not collect data on these. State Ombudsmen reported facing challenges while responding to facility-initiated discharges, such as nursing homes sending facility-initiated discharge notices that lack required information. Moreover, the COVID-19 pandemic exacerbated challenges. In addition, Ombudsmen, CMS, and State agencies may differ in their perspectives on regulations and enforcement of facility-initiated discharges. Following CMS's initiative to review and take appropriate enforcement action in cases of noncompliance with facility-initiated discharge requirements, State agencies cited many more nursing homes for not complying with notice requirements for discharges in 2018. CMS has not yet determined the trends and outcomes of its initiative.

What OIG Recommends

Our findings raise concerns about weaknesses in the safeguards to protect nursing home residents from harm that may result from inappropriate facility-initiated discharges. We recommend that CMS provide training to nursing homes, assess the effectiveness of its enforcement of inappropriate facility-initiated discharges, and implement its deferred initiatives to address

inappropriate facility-initiated discharges. CMS concurred with these recommendations. We recommend that ACL assist State Ombudsman programs with a data-collection system for facility-initiated discharge notices and establish guidance for analysis and reporting of data from these notices. ACL concurred with these recommendations. Finally, we recommend that ACL and CMS coordinate to strengthen safeguards to protect nursing home residents and ensure that all State Ombudsmen, State agencies, and CMS ROs have an ongoing venue to share information about facility-initiated discharges. ACL and CMS did not explicitly state whether they concurred with our recommendation to coordinate to strengthen safeguards to protect nursing home residents but stated that they will continue to work together as well as with other stakeholders to address concerns related to inappropriate discharges. ACL and CMS concurred with our recommendation to have an ongoing venue to share information about facility-initiated discharges.

TABLE OF CONTENTS

BACKGROUND

Objectives

1. To determine the extent to which State Long-Term Care Ombudsmen (State Ombudsmen) received and responded to facility-initiated discharge notices from nursing homes.
2. To determine the extent to which State Ombudsmen experienced challenges with addressing inappropriate facility-initiated discharges.
3. To determine the extent to which State survey agencies (State agencies) and the Centers for Medicare & Medicaid Services (CMS) identified and addressed inappropriate facility-initiated discharges.

The inappropriate facility-initiated discharge of a resident from a nursing home (i.e., a facility-initiated discharge that violates CMS regulations) can be unsafe and traumatic for the resident and his or her family.[1] To address these concerns, Congress passed the Nursing Home Reform Act of 1987 (Nursing Home Reform Act) to protect residents against inappropriate facility-initiated discharge.[2] However, facility-initiated discharges that violate Federal regulations remain a concern, raising questions about the extent to which the problem exists and is being addressed. In fact, the State Ombudsman programs, charged with resolving problems for nursing home residents, cited complaints about discharge and eviction more frequently than any other concern from 2013 through 2019.[3, 4]

Nursing homes routinely discharge residents safely and appropriately for reasons such as improved health or to receive specialized care, among others. However, CMS and the media have raised concerns about some nursing homes inappropriately discharging residents and the negative consequences of these discharges. CMS has noted that the most commonly reported reasons that residents are discharged are behavioral issues and that some discharges are driven by payment concerns.[5] In one example, a resident remained in the hospital for 7 months because the nursing home refused to readmit him.[6] Another report described some nursing homes discharging "less profitable" residents to make room for residents diagnosed with COVID-19, which generally provides the nursing home with higher reimbursements. According to the report, the police found one resident on the streets after a nursing home discharged him to an unlicensed boarding house without informing his family.[7]

Federal Regulations for Facility-Initiated Discharges in Nursing Homes

Facility-initiated discharges are discharges that the resident objects to, did not request, and/or do not align with the resident's stated goals for care and preferences. In the case of a facility-initiated discharge, the nursing home moves the resident to another nursing home or location in the community and is not expected to take the resident back.[8]

Federal regulations prohibit nursing homes from initiating the discharge of a resident except for a specified set of reasons.

Nursing homes may only initiate the discharge of a resident for six reasons.

1. The resident's welfare and the resident's needs cannot be met in the facility.
2. The resident's health has improved sufficiently so the resident no longer needs the services provided by the facility.
3. The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident.
4. The health of individuals in the facility would otherwise be endangered.
5. The resident has failed, after reasonable and appropriate notice, to pay.
6. The facility ceases to operate.

Source: 42 CFR § 483.15(c)(1)

Nursing homes must document all facility-initiated discharges in the resident's medical record and provide adequate notice to the resident. Documentation in the resident's medical record should include a discharge care plan and documented discussions with the resident or resident's representative regarding discharge planning and post-discharge care.[9] When a resident's needs cannot be met in the facility or when a resident no longer needs the services provided by the facility, only the resident's physician can document these reasons for discharge. When the safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident or the health of individuals in the facility would otherwise be endangered, any physician can document these reasons for discharge.[10]

In the case that the nursing home initiated the discharge because it cannot meet the resident's needs, the medical record must document the specific needs that cannot be met, the nursing home's attempts to meet those needs, and the service available at the receiving facility to meet those needs.[11] Generally, the nursing home must also provide notice to the resident and the resident's representative in writing at least 30 days in advance.[12] Notice of facility-initiated discharge must include specific information, such as the date and reason for discharge.

CMS requires nursing homes to include the following information in facility-initiated discharge notices:

- reason for discharge;
- specific location to which the resident will be moved;
- date of discharge;
- Information about the right to appeal the decision to discharge the resident;
- contact information for the State Ombudsman;
- contact information for the agency responsible for the protection and advocacy of individuals with developmental disabilities, when appropriate; and
- contact information for the agency responsible for the protection and advocacy of individuals with a mental disorder, when appropriate.

Source: 42 CFR §483.15(c)(5)

State Administrative Hearings

The resident has the right to appeal a facility-initiated discharge through an administrative hearing if the resident believes that the nursing home cannot justify the discharge.[13] The entity that holds administrative hearings varies by State (e.g., State Medicaid Office, State survey agency, or Office of Administrative Hearings). For assistance with administrative hearings, residents can appoint an authorized representative or contact their State Ombudsman.[14] Residents may also represent themselves in an administrative hearing.[15] If the official overseeing the hearing decides in favor of the resident, a designated entity within the State must ensure that the nursing home readmits the resident.[16]

CMS sets requirements for nursing homes related to appeals of facility-initiated discharges. Nursing homes must provide information in the discharge notice on the resident's appeal rights on the facility-initiated discharge notice, including the name, address (mailing and email), and telephone number of the entity that receives appeal requests.[17] The discharge notice must also include information on how to obtain an appeal form and assistance in completing the form and filing a request for appeal.[18] Furthermore, nursing homes are not allowed to discharge residents while an appeal is pending, unless keeping the resident in the nursing home can pose health or safety dangers to the resident or others in the nursing home. In such cases, the nursing home must document the danger that failure to discharge would pose.[19]

CMS Oversight and Enforcement

To participate in Medicare and/or Medicaid, a nursing home must be certified as meeting Federal requirements.[20] State survey agencies (State agencies) conduct certification surveys on behalf of CMS. These surveys evaluate the safety and quality of care nursing homes provide on average every 12 months but no less frequently than every 15 months.[21] In addition to certification surveys, State agencies conduct complaint investigations.[22] Residents, residents' families, nursing home staff, and Ombudsmen (with the resident's permission) can file complaints with State agencies. Prior to investigating a complaint, State agencies should contact the State Ombudsman to discuss the nature of the complaint and history of similar complaints in the nursing home.[23] State agencies can identify inappropriate facility-initiated discharges through both standard and complaint surveys.

When a nursing home fails to meet one or more Federal requirements, surveyors cite a deficiency. Surveyors follow CMS guidance when determining whether to cite deficiencies during a survey. CMS updated this guidance in November 2017, including the guidance for deficiencies related to facility-initiated discharges.[24]

According to CMS, deficiencies with the following Federal requirements may be associated with facility-initiated discharges:

- right to refuse certain transfers,
- admissions policy,
- transfer and discharge requirements (reason and documentation for transfer or discharge of resident),
- notice requirements before transfer or discharge,
- preparation for safe/orderly transfer or discharge,
- notice of bed hold policy before or upon transfer, and
- permitting residents to return to facility.

Source: CMS, "An Initiative To Address Facility Initiated Discharges That Violate Federal Regulations." S&C 18-08-NH, December 22, 2017.[25]

When State agencies identify deficiencies, in almost all cases CMS requires the nursing home to submit an acceptable plan of correction to the State agency and/or CMS.[26] The plan of correction must describe how the nursing home will address the deficiency, among other things.[27] CMS may also impose enforcement remedies that may include Civil Money Penalties (CMPs) or denial for new Medicare and Medicaid payments.[28] State agencies must send deficiencies to their CMS ROs for review and enforcement action under certain circumstances, such as when the deficiency has caused serious injury or harm.[29] CMS ROs may consider all types of deficiencies cited

and the nursing homes' history of noncompliance, among other factors, when imposing enforcement remedies.[30]

CMS Initiative To Review Facility-Initiated Discharge Deficiencies

In a December 2017 memo, CMS announced a new initiative to review cases of facility-initiated discharge deficiencies. Specifically, CMS instructed State agencies to send facility-initiated discharge deficiencies to the CMS ROs beyond those usually sent.[31] According to the memo, State agencies must send deficiencies for certain reasons unless otherwise instructed by the CMS RO. These reasons include cases where a nursing home discharges a resident to a "questionable or unsafe" location, cases where a nursing home will not readmit a hospitalized resident, cases that represent facility patterns, or cases that include "other circumstances" identified by the CMS RO. CMS ROs will review these deficiencies and take enforcement actions if deemed appropriate. CMS is also evaluating enforcement options for these types of deficiencies as part of the initiative. In its rationale for the initiative, CMS emphasizes concerns with inappropriate facility-initiated discharges and their effect on residents. This initiative represents part of CMS's efforts "to fully address facility-initiated discharges that violate federal regulations."[32]

ACL and State Ombudsmen

In addition to other functions, the Administration for Community Living (ACL) oversees programs that aim to protect the rights and prevent abuse of older adults, including the State Long-Term Care Ombudsman Program (State Ombudsmen).[33] The Older Americans Act authorized the creation of the State Ombudsman program that works to resolve problems related to the safety, welfare, and rights of individuals who live in nursing homes.[34] Ombudsmen advocate on behalf of nursing home residents to resolve complaints made by or for these residents.[35] The Ombudsman Program operates in all 50 States, the District of Columbia, Puerto Rico, and Guam.[36]

A full-time State Ombudsman heads the Ombudsman program in each State, and some programs have additional local offices.[37] The State Ombudsman designates and provides programmatic oversight to both paid staff and volunteers who serve as representatives of the Office of Long-Term Care Ombudsman. They conduct advocacy through two channels: (1) individual assistance to residents with concerns and (2) advocacy related to laws, regulations, and policies for long-term care residents. Ombudsmen must receive a resident's consent to assist with a problem.

Each State Ombudsman program reports the complaints they receive and investigate to ACL through the National Ombudsman Reporting System (NORS).[38] NORS includes, but is not limited to, information on types of complaints and outcomes, Ombudsman program information, and narratives on broader systems issues.[39, 40]

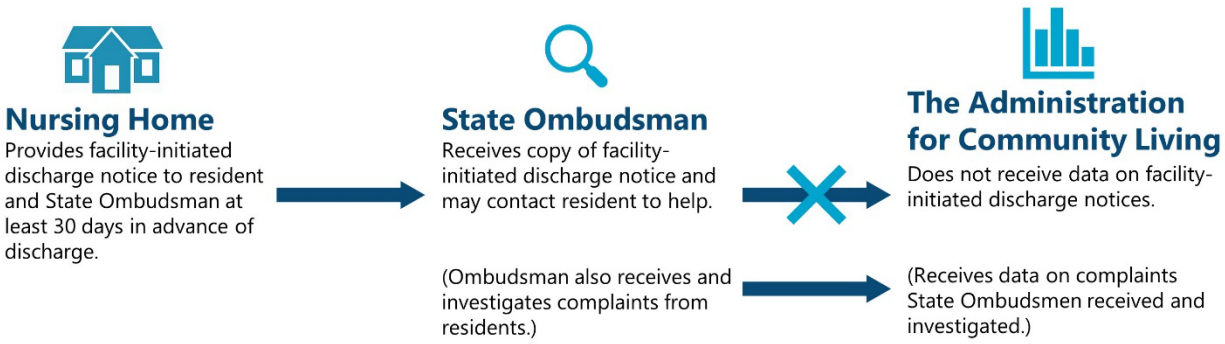
The State Ombudsman program has many functions mandated by law to improve the quality of life and care for residents, including, but not limited to:

- identifying, investigating, and resolving complaints made by or on behalf of residents;
- ensuring that residents have regular and timely access to Ombudsman services and receive timely responses from the Ombudsman program;
- representing the interests of residents before governmental agencies;
- analyzing, commenting on, and monitoring the development and implementation of laws, regulations, and policies pertaining to the health, safety, welfare, and rights of residents; and
- recommending changes to these laws.

Source: 45 CFR § 1324.13

Since November 2016, CMS regulations require nursing homes to send all facility-initiated discharge notices to a representative of the State Ombudsman program to "provide added protection" to residents.[41, 42] In general, nursing homes must send these notices at least 30 days in advance of discharge and include all information required for the discharge notice to be adequate.

Exhibit 1: State Ombudsmen receive facility-initiated discharge notices from nursing homes as well as complaints from residents, and ACL collects data on complaints from Ombudsmen.



Source: 42 CFR § 483.15(c)(3)(i) and 81 Federal Register 68688, 68734 (Oct. 4, 2016).

The COVID-19 Pandemic

COVID-19 is a highly contagious disease and can be fatal in some cases.[43, 44] Nursing home residents are particularly vulnerable to the disease due to their age and underlying health conditions. As of April 4, 2021, more than 131,000 nursing home residents died due to COVID-19.[45] On January 31, 2020, the Secretary of the

Department of Health and Human Services (HHS) declared a public health emergency, and on March 13, 2020, the Federal Government declared a national emergency in response to the COVID-19 pandemic.[46] After these declarations, CMS issued certain waivers to provide nursing homes with the flexibilities to respond to the COVID-19 pandemic.[47] Specifically, CMS waived certain facility-initiated discharge requirements for the purposes of separating residents due to COVID-19. For example, CMS waived the requirement that, in most cases, nursing homes must provide a facility-initiated discharge notice to the resident 30 days before discharge. Instead, nursing homes need to provide the notice as soon as practicable when discharging a resident for purposes of separating residents due to COVID-19.[48]

CMS also issued guidance to nursing homes regarding visitation protocols during the COVID-19 pandemic. On March 13, 2020, CMS provided guidance to restrict all visitors and nonessential health care personnel in nursing homes, including Ombudsmen, with the exception of health care workers and surveyors.[49] However, CMS issued additional guidance in July 2020 reminding nursing homes that they must provide Ombudsmen with access to residents through phone or other technology if the nursing home restricts in-person visits.[50] On September 17, 2020, CMS updated its visitation guidance with recommendations on how nursing homes can safely facilitate in-person visits while preventing the spread of COVID-19. The guidance noted that nursing homes cannot limit residents' in-person access to Ombudsmen without reasonable cause, such as Ombudsmen having symptoms of COVID-19.[51] On March 10, 2021, CMS updated its guidance to recommend that nursing homes allow responsible indoor visitation at all times for all residents, with some exceptions.[52]

Related OIG Work

This study is part of the Office of Inspector General's (OIG's) larger body of work examining nursing home resident safety and oversight. Most recently, OIG published a report examining CMS's and State agencies' onsite oversight of nursing homes during the COVID-19 pandemic.[53] OIG also published a report examining staffing levels in nursing homes and a report evaluating States' timeliness investigating the most serious nursing home complaints.[54, 55] In addition, OIG has work underway examining CMS's efforts to work with State agencies to improve nursing home oversight.[56] Finally, to complement this evaluation, OIG is also assessing nursing homes' compliance with Federal requirements for facility-initiated discharges. A complete listing of OIG's ongoing evaluations and audits is available in our online Work Plan at https://www.oig.hhs.gov/.

Methodology

Our review includes the following data sources: (1) survey of State Ombudsmen, (2) CMS survey and deficiency data, (3) interviews with State Ombudsmen, and (4) interviews with CMS and ACL. We consider facility-initiated discharges from both Medicare and Medicaid-only nursing homes in our review. Most of our data refer to

calendar years 2017 and 2018, the latest data available when we initiated this evaluation. However, OIG put this evaluation on hold for several months to direct its resources to concerns related to the COVID-19 pandemic. When we resumed this work in late calendar year 2020, we interviewed five State Ombudsmen to provide insights on how the pandemic affected facility-initiated discharges.

Data Sources and Analysis

Survey of State Ombudsmen. We sent an electronic survey to the State Ombudsman in all 50 States and the District of Columbia. State Ombudsmen could respond to the survey from June 3, 2019, through September 5, 2019. We received responses from 47 State Ombudsmen, for a response rate of 92 percent. We analyzed their responses to describe Ombudsmen's experiences and challenges with receiving, investigating, and resolving facility-initiated discharge notices. We also analyzed their responses related to their experiences working with State agencies and CMS ROs on facility-initiated discharges. All survey questions referred to calendar years 2017 and/or 2018.

CMS Survey and Deficiency Data. CMS provided data on all standard and complaint surveys and resulting deficiencies of Medicare/Medicaid-certified nursing homes from CMS's Certification and Survey Provider Enhanced Reporting (CASPER) and Automated Survey Process Environment (ASPEN) for years 2014 through 2018. We analyzed trends in deficiencies related to facility-initiated discharges from 2014 through 2018 to determine the number and percentage of deficiencies that may relate to facility-initiated discharges over time and by State.

Interviews With State Ombudsmen. We conducted structured interviews with a purposive sample of five State Ombudsmen in October and November 2020. We asked the State Ombudsmen about the impact of the COVID-19 pandemic on facility-initiated discharges in nursing homes. We analyzed these interviews to identify themes.

Interviews With CMS and ACL. We conducted structured interviews with all 10 CMS ROs in July 2019. We asked CMS ROs about their implementation of CMS's December 2017 memo to address inappropriate facility-initiated discharges. In addition, we conducted multiple interviews with CMS and ACL Headquarters staff from 2018 through 2020. We asked about each agency's efforts to address inappropriate facility-initiated discharges and about challenges they face in doing so, among other questions. In addition, we asked CMS and ACL staff about the impact of the COVID-19 pandemic on facility-initiated discharges.

See the Detailed Methodology section on page 25 for additional information about our data collection and analysis.

Limitations

We did not independently verify the survey responses that State Ombudsmen provided. Data from the State Ombudsmen survey represent the views and experiences of the 47 responding State Ombudsmen rather than all 51 State Ombudsmen. We also did not independently verify the accuracy of CMS's CASPER and ASPEN data. Finally, we did not interview State agencies for this evaluation and cannot make statements about their experiences with facility-initiated discharges in nursing homes.

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

The magnitude of facility-initiated discharges in nursing homes is unknown

Neither ACL nor CMS know the number of facility-initiated discharges in nursing homes or the number of these discharges that are inappropriate because they do not collect these data. Although CMS requires nursing homes to send a copy of all facility-initiated discharge notices to their State Ombudsmen, ACL does not collect data on these notices from the Ombudsmen.[57] ACL collects national-level data, such as complaints that Ombudsmen receive, which may concern inappropriate facility-initiated discharges among other complaints.[58] Furthermore, CMS's data on inappropriate facility-initiated discharges are limited to State agency citations for deficiencies related to these discharges. Neither CMS nor ACL has plans to collect additional data on facility-initiated discharges.

24 of 47 Ombudsmen could not provide the number of facility-initiated discharge notices they received in 2018

Although State Ombudsmen receive facility-initiated discharge notices, many do not count or extract information from the notices received. In fact, 24 of 47 Ombudsmen could not provide the number of notices they received in 2018. Furthermore, our review indicates that even those who provided the number of notices may not have provided a complete or accurate number. For example, two Ombudsmen told us they provided numbers of complaints related to facility-initiated discharges rather than notices received, and another Ombudsman provided numbers that included other types of notices. In addition, at least one Ombudsman manually counted the notices in response to our survey. Some Ombudsmen reported receiving fewer than 10 notices in 2018, while others reported receiving more than 1,000 notices. Although State size may affect the number of notices received, it likely does not explain the large variation between State Ombudsman programs. Also, most Ombudsmen (31 of 47) could not provide data on the reason for discharge included in the notices.

> "Our State LTCO Program simply does not capture the data points being requested."
>
> **–State Ombudsman**

Ombudsmen attribute their inability to count or extract information from the notices they receive, at least in part, to limited resources. A few Ombudsmen told us that they do not have an established database to collect data on facility-initiated discharge notices. Instead, they use a database designed to collect data on complaints and Ombudsman activity to report this information to ACL. One Ombudsman volunteered that her "database does not have a field for capturing the total number of facility-initiated discharge letters [notices] since this is not a NORS [National Ombudsman Reporting System] requirement." This means that Ombudsmen who decide to track

notices need to develop and implement their own system to do so, which may require significant resources. Indeed, one Ombudsman said that the program hired an additional staff member to help track notices but described this process as "time-consuming." Nine other Ombudsmen told us that they do not have enough staff to extract data from the notices.

Many Ombudsmen expressed concerns about inappropriate facility-initiated discharges, and some described the negative effects on residents. For example, most Ombudsmen (41 of 47) agreed that nursing homes discharging a resident while the resident is in the hospital is a problem in their States. One Ombudsman described a situation prior to the COVID-19 pandemic where a nursing home initially refused to readmit a resident after sending him to the emergency room; as a result, the resident ended up homeless for a week. The Ombudsman assisted the resident with an appeal and the resident eventually returned to the nursing home. In addition, most Ombudsmen (41 of 47) agreed that in their State, nursing homes discharging a resident to an inappropriate location is a problem. One Ombudsman told us that a nursing home discharged a resident "with complex and ongoing medical needs" to a motel, only notifying the resident's family when the resident was in transit. By the time the family arrived, the resident was in "acute physical distress" and needed hospital care. Similarly, another Ombudsman said that a nursing home in his State discharged a wheelchair-bound resident to a hotel, and "within hours" the resident was "unresponsive and required emergency medical treatment."

One Ombudsman provided examples of facility-initiated discharges that were tied to the COVID-19 pandemic.

The stress of the pandemic, isolation, and limits on visitors affected some residents' behaviors. For example, the behavior of one resident with dementia became more problematic without regular visits from his spouse. Ultimately, the nursing home called the police to transport the resident to the hospital. The hospital would not admit him, and the nursing home refused to allow him back. The Ombudsman helped the resident find another facility that would admit him.

Another nursing home restricted residents from leaving, even for a walk, during the pandemic. When one resident violated the policy and left, the nursing home discharged the resident to the hospital, which refused to admit him. The hospital gave the resident bus fare to leave and a nursing home 3 hours away from the original nursing home eventually admitted the resident.

Ombudsmen reported facing challenges while responding to facility-initiated discharges

As part of their duties, Ombudsmen must respond to complaints made by or on behalf of nursing home residents. Ombudsmen may also offer assistance to residents

in the absence of a complaint but must have the resident's permission to provide assistance. For example, Ombudsmen can contact the resident associated with a facility-initiated discharge notice and, if given permission by the resident, investigate the discharge.

Ombudsmen vary in how they identify which facility-initiated discharge notices to respond to

Ombudsmen have discretion in determining which notices they respond to. In most cases, the local representatives of the Ombudsman program, overseen by the State Ombudsman, contact the resident associated with a facility-initiated discharge notice, but Ombudsmen vary in determining which residents to contact. Just over one-third of Ombudsmen (17 of 47) contact every resident or most residents associated with a facility-initiated discharge notice, while others contact the resident only when the notice appears to be noncompliant with regulations or only when a complaint is made. In addition, two Ombudsmen outlined additional criteria that they use to identify notices for follow up, such as nonpayment as the reason for discharge and a nursing homes' history with discharges. Most Ombudsmen (30 of 47) told us they can respond to each notice they identify for followup.

After receiving permission from the resident, Ombudsmen conduct a variety of activities when investigating and resolving those facility-initiated discharge notices they identified for followup. Over half said that they interview the resident or resident's representative, interview the nursing home administrative staff, or review the resident's discharge summary in most if not all investigations. In addition, most Ombudsmen contact the nursing home directly all or most of the time to resolve a facility-initiated discharge notice. For those Ombudsmen who contact the nursing home, about half said that most of the time, this results in a satisfactory outcome for the resident.

Noncompliant facility-initiated discharge notices hinder Ombudsmen's ability to investigate and resolve these discharges

Receiving timely, complete, and accurate facility-initiated discharge notices provides the Ombudsmen the best opportunity to investigate and resolve the situation. However, 31 of 47 Ombudsmen reported that nursing homes in their States do not have a clear understanding of CMS's requirements for facility-initiated discharge notices. (See Exhibit 2.)

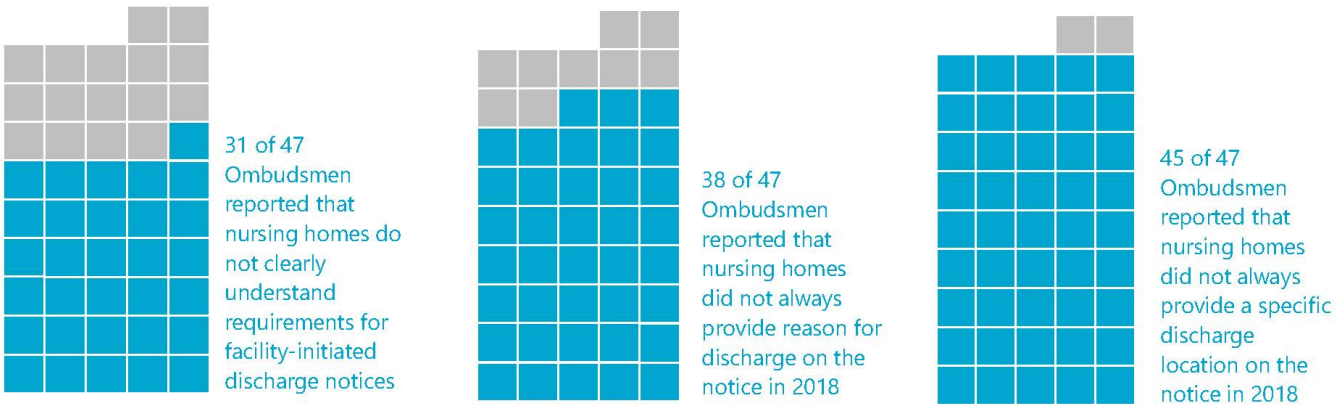
Timeliness. Some Ombudsmen told us that nursing homes do not send notices in a timely manner or send notices after the discharge occurred. Thirteen Ombudsmen volunteered that receiving notices close to or after discharge is a challenge, with one Ombudsman noting that this makes it "difficult to get out to assist the resident prior to discharge." Another Ombudsman told us that in some cases, the resident has already left the facility by the time the Ombudsman receives the discharge notice.

Indeed, 40 of 47 Ombudsmen found achieving a resolution before a nursing home discharges a resident to be a challenge.

> "Facility staff usually are not familiar with the regulations regarding when to send discharge notices and what information they should contain."
>
> **–State Ombudsman**

Missing Information. In addition, nursing homes send Ombudsmen facility-initiated discharge notices with required information missing. CMS requires nursing homes to include the reason for discharge and the specific discharge location in the notices. However, for the year 2018, a total of 38 Ombudsmen said that nursing homes did not always provide the reason for discharge on the notice, and 45 Ombudsmen said that nursing homes did not always provide a specific discharge location on the notice (see Exhibit 2). Almost all (43 of 47) Ombudsmen found that receiving notices with required information missing was a challenge to investigating notices.

Exhibit 2: Most Ombudsmen reported that nursing homes in their State do not clearly understand requirements for facility-initiated discharge notices.



Source: OIG analysis of survey of State Ombudsmen.

Unnecessary Notices. Lastly, Ombudsmen reported receiving notices beyond those CMS requires, such as for room transfers within a nursing home. In fact, 36 of 47 Ombudsmen found receiving these additional notices to be a challenge. A State Ombudsman told us that one nursing home in her State continues to send facility-initiated discharge notices to the resident's family and the State Ombudsman when a resident dies, with the reason that the nursing home can no longer meet the

resident's needs. Receiving notices beyond what CMS requires creates additional burden for Ombudsmen programs to review and determine which notices should be tracked and investigated. In response to our survey, 43 of 47 Ombudsmen indicated that having too few local representatives in the State Ombudsman program was a challenge to investigating facility-initiated discharges.

"Nursing homes struggle with understanding what is facility-initiated and, as a result, nursing homes either send notices not required by regulations or do not send notices at all."

–State Ombudsman

Almost all Ombudsmen said that they conducted outreach to help nursing homes in their States comply with notice requirements. For example, one State Ombudsman told us that his program developed a booklet outlining requirements for facility-initiated discharge notices to send to all nursing homes in the State. Another State Ombudsman volunteered that her program provided nursing homes that issued incorrect notices with a template to help these nursing homes comply with notice requirements.

The COVID-19 pandemic exacerbated challenges that Ombudsmen face with receiving notices for, investigating, and resolving facility-initiated discharges.

Some of the Ombudsmen we interviewed told us that they had challenges receiving facility-initiated discharge notices during the COVID-19 pandemic. CMS waived the requirement for nursing homes to provide a facility-initiated discharge notice 30 days prior to discharge, but only for those discharges initiated to prevent the spread of COVID-19. For these discharges, nursing homes must provide the notice as soon practicable. For discharges not related to preventing the spread of COVID-19, nursing homes generally must continue to provide notices 30 days prior to discharge. However, some Ombudsmen expressed concerns that, early in the pandemic, nursing homes were not issuing the required notices on time or at all. Moreover, one Ombudsman told us that her program had to ask her State agency to instruct nursing homes to send notices.

In addition, CMS provided guidance to restrict Ombudsmen's in-person visits to nursing homes early in the pandemic, presenting a challenge to investigating and resolving facility-initiated discharges. Although Ombudsmen used the telephone and other virtual technology to communicate with residents and nursing homes, one Ombudsman said that it was a struggle to reach nursing homes through these means. In addition, two Ombudsmen noted that, without in-person visits, they could not observe conditions in the nursing home, which hindered investigations.

The administrative hearing process does not always resolve the facility-initiated discharge as intended

According to State Ombudsmen, the administrative hearing process falls short of protecting residents against inappropriate facility-initiated discharges. CMS requires that a designated entity within the State ensure that nursing homes readmit a resident when the resident wins an administrative hearing.[59, 60] However, nearly two-thirds of Ombudsmen (30 of 47) said that enforcing an administrative hearing decision that is favorable to the resident is a challenge in their States. Two Ombudsmen told us that residents may still be discharged from the nursing home even after winning an appeal. Furthermore, over one-quarter of Ombudsmen (13 of 47) said that no entities in their States are responsible for enforcing administrative hearing decisions. Problems with enforcement may affect nursing homes' compliance with facility-initiated discharge regulations. According to CMS, a favorable administrative hearing for the resident may prompt nursing homes to increase compliance with regulations for facility-initiated discharges, resulting in fewer deficiencies. However, CMS noted that it does not have much information about States' processes for administrative hearings.

> "If a resident facing discharge does not have a professional advocate (like an Ombudsman) or legal representation, the nursing home is going to get the OK to discharge the resident."
>
> **–State Ombudsman**

Ombudsmen reported additional challenges with the administrative hearing process. Nearly all Ombudsmen found the resident's lack of knowledge regarding administrative hearings to be a challenge, with over half finding it to be a major challenge. In addition, five Ombudsmen told us that State hearing officers were unfamiliar with facility-initiated discharge regulations. A few specifically noted that some hearing officers focus on State regulations for discharge and are unfamiliar with or do not consider Federal regulations. Finally, four Ombudsmen said that increasing resident access to legal resources would help Ombudsmen better address facility-initiated discharges.

Ombudsmen, CMS, and State agencies may differ in their perspectives on facility-initiated discharges

Perspectives on the effectiveness of enforcement varied. Although Ombudsmen do not cite deficiencies and take enforcement actions, they do work directly with residents to resolve facility-initiated discharges and have knowledge of the circumstances of individual discharges. Half of Ombudsmen raised questions about how well enforcement addressed inappropriate facility-

> "When a hearing officer sides with the resident, it doesn't confirm that [the] resident isn't discharged."
>
> **–State Ombudsman**

initiated discharges. For example, a few Ombudsmen volunteered that nursing homes have said that they would rather accept a deficiency or enforcement penalty than keep the resident. And several Ombudsmen opined that stronger enforcement actions could help to reduce these discharges. However, CMS ROs did not generally share those concerns. Half of CMS ROs volunteered that enforcement tools are adequate to address inappropriate facility-initiated discharges, and 7 of 10 CMS ROs told us that they do not consider these discharges a problem in their regions. Notably, CMS ROs consider factors in addition to the specific deficiency when taking enforcement action, such as a nursing homes' history of noncompliance, which may contribute to the difference in perspectives between CMS ROs and Ombudsmen.

A common understanding of the regulations for facility-initiated discharges also appeared to be lacking. For example, about half of Ombudsmen (23 of 47) stated that interpreting regulations for facility-initiated discharges differently than their State agencies was a challenge. One CMS RO offered an example. Specifically, an Ombudsman informed the CMS RO of facility-initiated discharges that the State agency did not consider facility-initiated. This discrepancy led the CMS RO to step in and clarify the definition of facility-initiated discharge with the State agency. The CMS RO also had Federal surveyors accompany the State agency on the complaint investigation related to these discharges.

> "The State Survey Agency has a different understanding of what constitutes a facility-initiated discharge."
>
> **–State Ombudsman**

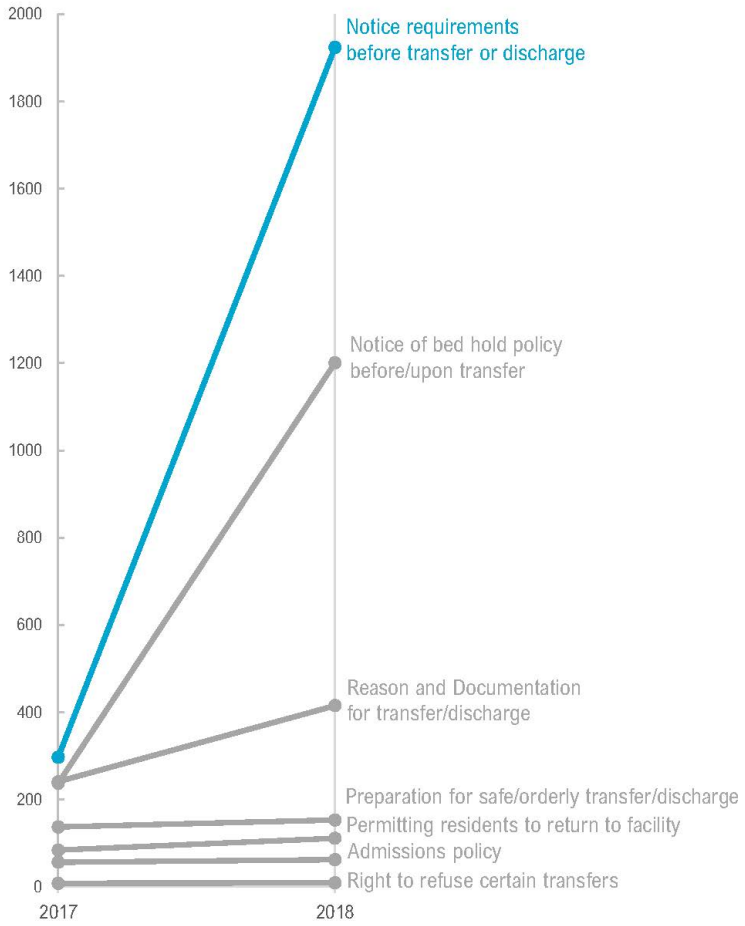
CMS and ACL may be missing opportunities to foster a common understanding of regulations and reduce inappropriate facility-initiated discharges. Six of 10 CMS ROs do not regularly communicate with the Ombudsmen in their regions about facility-initiated discharges. Furthermore, ACL does not have specific plans to facilitate communication between CMS and the Ombudsmen. ACL said that it previously hosted a few regional meetings with both Ombudsmen and CMS ROs to discuss systemic problems in nursing homes, including inappropriate facility-initiated discharges. A common understanding among Ombudsmen, CMS, and State agencies benefits nursing home residents because these entities rely on each other for referring complaints, sharing information, and ultimately resolving facility-initiated discharges.

State agencies cited many more nursing homes for not complying with notice requirements following CMS's initiative to review inappropriate facility-initiated discharges, announced in 2017

State agencies cited more than six times as many nursing homes for deficiencies with facility-initiated discharge notices in 2018 compared to 2017.[61] Coupled with CMS's

updated survey guidance, CMS's initiative to review cases of facility-initiated discharge deficiencies, which it announced in a memo issued in December 2017, may have contributed to this increase in deficiencies. In 2018, State agencies cited 1,924 nursing homes (13 percent of those surveyed) for a deficiency with facility-initiated discharge notices, an increase from 297 nursing homes (2 percent of those surveyed) in 2017 (see Exhibit 3 below). From 2014 through 2016, State agencies cited about 200 nursing homes for this deficiency each year (about 1 percent of nursing homes surveyed). Nearly all States (48 of 51) cited more nursing homes for this deficiency from 2017 to 2018.

Exhibit 3: State agencies cited many more nursing homes for not complying with notice requirements before transfer or discharge in 2018 than in 2017.



Source: OIG analysis of CMS CASPER and ASPEN data, 2017–2018

However, we cannot directly tie these specific deficiencies to enforcement actions taken by CMS. Rather than considering a single deficiency, CMS typically considers all cited deficiencies for a nursing home during a survey as well as other factors, such as the nursing homes' history of compliance, when taking enforcement actions.

CMS has not yet determined the trends and outcomes of its initiative to review and impose appropriate enforcement actions in cases of inappropriate facility-initiated discharges

The results of CMS's initiative to review deficiencies for facility-initiated discharges and take appropriate enforcement actions are unknown. CMS told us it could not readily identify the number of cases State agencies sent in response to CMS's memo without reviewing each case individually. Some CMS ROs provided us an estimate for the number of cases State agencies transferred to the RO since CMS released the memo, which varied from 0 cases for one RO to over 100 cases for another RO.[62] CMS has also noted, as acknowledged previously, that it considers more than a single deficiency in determining its enforcement actions. Therefore, it is unclear how CMS intends to evaluate enforcement actions imposed because of its memo.

However, 5 of the 10 CMS ROs volunteered that they have taken enforcement actions for at least 27 inappropriate facility-initiated discharges (as of July 2019) because of the additional review prompted by CMS's December 2017 memo. For example, one RO imposed a CMP on a nursing home for refusing to readmit a resident from the hospital and for failing to properly document the reason for discharge in the medical record. Two other CMS ROs imposed a CMP on nursing homes for failing to provide facility-initiated discharge notices to residents.

CMS postponed its planned actions to address inappropriate facility-initiated discharges because of COVID-19.

According to CMS Headquarters, it plans to take actions to address inappropriate facility-initiated discharges, such as providing training to State surveyors on discharge requirements and implementing a Federal workgroup to discuss concerns related to facility-initiated discharges.

CONCLUSION AND RECOMMENDATIONS

Our findings raise concerns about weaknesses in the safeguards to protect nursing home residents from harm that may result from inappropriate facility-initiated discharges. State Ombudsmen, ACL, State agencies, and CMS share a common goal to protect residents from harm, but have different roles stemming from different authorities. Those differences may, in fact, inhibit efforts to prevent inappropriate facility-initiated discharges. CMS and State agencies are regulatory entities responsible for ensuring nursing home compliance and can take enforcement action against nursing homes to address inappropriate discharges. In contrast, ACL and State Ombudsmen serve in a resident advocacy role and directly assist residents. State Ombudsmen receive notices of facility-initiated discharges—positioning them to advocate where necessary. We found that State Ombudsmen, CMS, and State agencies may differ in their perspectives on regulations and enforcement of facility-initiated discharges Improved information—including fully compliant notices from nursing homes on their facility-initiated discharges—as well as coordination and information sharing could better protect nursing home residents from harm.

Critical questions remain, including how many residents are subject to facility-initiated discharges in nursing homes, how many of those discharges are inappropriate, which nursing homes have concerning rates or patterns of facility-initiated discharges, and how well oversight and enforcement address and reduce inappropriate discharges. Answers to these questions would provide important information to aid those responsible for safeguarding residents. Answers would allow for targeted interventions and enhanced oversight with the goal to reduce harm to residents from inappropriate discharges.

We have forthcoming work that will determine the extent to which a sample of nursing homes followed regulations for facility-initiated discharges in 2019.[63] In the meantime, this report highlights opportunities to strengthen the safeguards in place to ensure residents' rights and prevent inappropriate discharges. To that end, we offer recommendations to CMS, which oversees nursing homes, to ACL, which oversees the Ombudsman program, and joint recommendations to both agencies.

We recommend that CMS:

Provide training for nursing homes on Federal requirements for facility-initiated discharge notices

Ombudsmen rely on timely and accurate facility-initiated discharge notices to fulfill their responsibilities of protecting residents and staying informed of facility activities.

But not all nursing homes consistently follow the requirements, which can hinder Ombudsmen's ability to investigate potentially inappropriate discharges. Improving nursing homes' understanding of and compliance with notice requirements would help Ombudsmen better protect residents from inappropriate facility-initiated discharges.

CMS should provide training for nursing homes on the Federal requirements for facility-initiated discharge notices. This training should include when to send the notices to State Ombudsmen, the types of notices that nursing homes need to send to State Ombudsmen, and information required in the notices. Specifically, CMS should highlight the importance of including the specific discharge location in the notice.

Assess the effectiveness of its enforcement of inappropriate facility-initiated discharges

In its December 2017 memo, CMS outlined an initiative to "examine and mitigate facility-initiated discharges that violate federal regulations." However, it is unclear how CMS is evaluating enforcement actions imposed in response to the memo because CMS cannot readily identify the number of cases received from State agencies. CMS should evaluate the enforcement actions imposed in noncompliant facility-initiated discharge cases. CMS could do this by determining how many cases State agencies have transferred to ROs and analyzing the enforcement remedies that CMS imposed in these cases considering all the relevant factors. CMS could also assess differences in deficiencies transferred and enforcement actions across State agencies and CMS ROs to identify any inconsistencies that should be addressed. CMS could use the results of this assessment to inform guidance and training for State agencies and CMS ROs related to its initiative.

Implement its deferred initiatives to address inappropriate facility-initiated discharges

Prior to the COVID-19 pandemic, CMS was working on developing and implementing initiatives to address inappropriate facility-initiated discharges in nursing homes, including: developing guidance for States to respond to complaints, training State surveyors on discharge requirements and CMS's survey guidance, implementing a Federal workgroup to discuss concerns related to facility-initiated discharges, and identifying root causes of inappropriate facility-initiated discharges. CMS postponed these actions due to the COVID-19 pandemic. Once appropriate, CMS should implement these actions to help reduce inappropriate facility-initiated discharges.

We recommend that ACL:

Assist State Ombudsman programs in establishing a data-collection system for facility-initiated discharge notices

Many State Ombudsman programs could not provide data from the facility-initiated discharge notices they receive from nursing homes. Having information on the extent and nature of facility-initiated discharges would help Ombudsmen learn of nursing home practices, establish best practices for triaging notices, and develop a targeted response to address inappropriate discharges – all of which would enhance Ombudsmen's advocacy of residents experiencing inappropriate discharges and better protect residents from harm. We recognize that ACL and State Ombudsman programs have limited resources to establish a data collection system. However, taking steps to collect data from facility-initiated discharge notices is a critical first step.

To start, ACL should provide State Ombudsman programs with technical assistance to establish a system to count and extract information from facility-initiated discharge notices. Each State Ombudsman program should aim to determine the number of notices received, the reasons nursing homes provide for discharge, and the discharge locations. ACL could establish best practices from State Ombudsman programs that have already developed effective systems and share those practices.

ACL could consider other avenues for collecting these data. For example, it could work with State Ombudsman programs to develop a template for notices in each State to make it easier for Ombudsmen to abstract information from notices—this could also help nursing homes comply with notice requirements.

Establish guidance for analysis and reporting of data collected by State Ombudsman programs from facility-initiated discharge notices

Having data on facility-initiated discharge notices creates opportunities for deeper understanding through analysis and for enhanced advocacy to protect residents from harm. Establishing expectations for analysis ensures progress toward that understanding and enhanced advocacy. At a minimum, each State Ombudsman program should be able to determine the number of facility-initiated discharge notices received from each nursing home in their State within a given time period. ACL could instruct State Ombudsman programs to analyze the reasons for discharge and discharge locations on the notices on a regular basis through written guidance. Identifying patterns in the number, reasons, and locations of these discharges would help Ombudsmen target advocacy efforts to residents of nursing homes whose discharge practices raise concerns (e.g., nursing homes initiating a large number of discharges or discharging residents to inappropriate locations). In addition, ACL

could require State Ombudsmen to report this information to ACL on an annual basis, as it does with complaint data. This would allow ACL to aggregate data from facility-initiated discharge notices at the national level.

We recommend that ACL and CMS:

Coordinate to strengthen safeguards to protect nursing home residents from inappropriate facility-initiated discharges

ACL and CMS should work together to improve safeguards to protect residents from inappropriate facility-initiated discharges. Specifically, ACL and CMS should collaborate on collecting data from facility-initiated discharge notices, such as through an electronic portal, to allow for easier data abstraction. In addition, ACL and CMS could determine whether State agencies could benefit from receiving facility-initiated discharge notices in addition to the State Ombudsman program, which is the only entity that currently receives them. State agencies could use the notices to identify nursing homes that discharge residents to inappropriate locations and educate those nursing homes about appropriate discharge practices. CMS and ACL could coordinate to determine if the information from discharge notices would help improve State agencies' oversight of inappropriate discharges.

Ensure that all State Ombudsmen, State agencies, and CMS ROs have an ongoing venue to share information about facility-initiated discharges and potentially other systemic problems in nursing homes

Both State Ombudsmen and State agencies share the goal of protecting residents from inappropriate discharges and often work together to do so. Developing a common understanding of regulations for facility-initiated discharges would strengthen this collaboration and help reduce inappropriate facility-initiated discharges.

ACL and CMS could establish ongoing regional venues to ensure that all State Ombudsmen, State agencies, and CMS ROs can communicate and share information with one another about facility-initiated discharges. This venue could take different forms, such as an annual meeting within each CMS Region dedicated to discussing problems with facility-initiated discharges and/or a website where State Ombudsmen can ask their CMS RO questions about facility-initiated discharges and share concerns. In addition, this venue could provide State Ombudsmen the opportunity to share data extracted from facility-initiated discharge notices with their State agencies and CMS ROs. Finally, CMS ROs could use this venue to share information about oversight and enforcement practices, including the assessment of their December 2017 memo.

AGENCY COMMENTS AND OIG RESPONSE

In its comments, CMS concurred with our first three recommendations and stated that it will make training available on Federal requirements related to facility-initiated discharge notices to all Long-Term Care stakeholders. CMS also stated that it will assess the effectiveness of its enforcement actions imposed in noncompliant facility-initiated discharge cases but noted that such an evaluation would take time and will also depend on the public health emergency and resources. Lastly, CMS stated that, as soon as possible, it will implement a variety of initiatives to address inappropriate facility-initiated discharges that were paused during the COVID-19 pandemic. We look forward to details on CMS's plan to implement these recommendations in its Final Management decision.

In its comments, ACL concurred with our fourth recommendation and stated that it will continue to provide State Ombudsmen programs with technical assistance to help them establish systems to count and extract information from facility-initiated discharge notices. We ask that ACL, in its Final Management Decision, provide details on the additional steps it will take to assist State Ombudsmen programs in establishing a system to specifically collect information from facility-initiated discharge notices.

ACL also concurred with our fifth recommendation and stated that it will continue to work with State Ombudsmen and the National Ombudsman Resource Center to provide guidance, training, and technical assistance in assessing and tracking information on facility-initiated discharge notices for analysis. ACL also noted the benefits of the National Ombudsman Reporting System (NORS) that tracks complaints and provided examples on how complaint data improves advocacy to address facility-initiated discharges. We acknowledge ACL's efforts in collecting complaint data and appreciate the examples of how these data improve advocacy. However, NORS does not collect data on all facility-initiated notices. We continue to recommend that ACL assist State Ombudsmen to collect and analyze data on facility-initiated discharge notices, beyond complaint data, as the information can create a deeper understanding of the effects of facility-initiated discharges on residents and enhance advocacy. We look forward to ACL's sharing, in its Final Management Decision, its plan to assist State Ombudsmen programs in establishing a system to specifically analyze facility-initiated discharge notices.

ACL and CMS did not explicitly state whether they concurred with our joint recommendation to improve coordination between the two agencies; however, they expressed commitment to working closely together and with other stakeholders to strengthen safeguards that protect nursing home residents from inappropriate facility-initiated discharges. We appreciate this commitment and ask that their collaboration include collection of data from facility-initiated discharge notices and

consider providing discharge notices to State agencies in addition to State Ombudsmen. In its comments, ACL noted that the State Ombudsmen are primarily focused on addressing facility-initiated discharges that the resident objects to, regardless of whether the discharge complied with CMS requirements. However, improved coordination between ACL and CMS can help State Agencies identify inappropriate facility-initiated discharges that a resident may not have objected to yet warrants enforcement actions. We ask that ACL and CMS provide details in their Final Management Decision on how they plan to implement this recommendation.

ACL and CMS concurred with OIG's joint recommendation that all State Ombudsmen, State agencies, and CMS ROs have an ongoing venue to share information about facility-initiated discharges. However, ACL and CMS did not provide details on how they plan to implement the recommendation. We recognize that some regions have a venue for CMS, State Ombudsmen, and State agencies to discuss facility-initiated discharges, and we emphasize the importance for CMS officials, State Ombudsmen, and State agencies in all regions to have such an opportunity to share information. We ask that ACL and CMS provide additional details on their plans to implement the recommendation in their Final Management Decision.

DETAILED METHODOLOGY

Data Sources

This study used the following data sources: (1) an electronic survey administered to State Ombudsmen, (2) deficiency and enforcement data from CMS's Certification and Survey Provider Enhanced Reporting (CASPER) and Automated Survey Process Environment (ASPEN) systems, (3) interviews with a purposive sample of five State Ombudsmen, (4) interviews with the 10 CMS ROs, (5) interviews with CMS headquarters staff, and (6) interviews with ACL headquarters staff.

Data Analysis

State Ombudsman Survey

We sent an electronic survey to State Ombudsmen in all 50 States and the District of Columbia. State Ombudsmen could respond to the survey from June 3, 2019, through September 5, 2019. We received responses from 47 State Ombudsmen, for a response rate of 92 percent. State Ombudsmen in Arizona, District of Columbia, Iowa, and Tennessee did not respond to the survey. The survey included questions related to Ombudsmen's experiences and challenges with receiving facility-initiated discharge notices, and with investigating and resolving these discharges. The survey also included questions about Ombudsmen's collaboration with State agencies and CMS ROs to address facility-initiated discharges and data on the number of facility-initiated discharge notices that Ombudsmen received. All survey questions refer to calendar years 2017 and/or 2018.

Some questions in our survey offered response options on a 3- or 4-point ranked scale. For some questions, respondents could choose "major challenge," "minor challenge," or "not a challenge." For another question, respondents could choose "strongly agree," "somewhat agree," "somewhat disagree," or "strongly disagree." We report our findings by aggregating all categories that positively identify something as challenging or that identify the respondent as being in agreement. Other questions in the survey offered open-ended responses. We categorized responses to open-ended questions by theme.

We analyzed data from our survey to describe Ombudsmen's experiences and challenges with receiving, investigating, and resolving facility-initiated discharge notices. We also analyzed data on Ombudsmen's experiences working with State agencies and CMS ROs on facility-initiated discharges.

CMS Deficiency and Enforcement Data

CMS provided us data on all standard and complaint surveys, deficiencies, and enforcement actions of Medicare/Medicaid-certified nursing homes from CMS's CASPER/ASPEN system for years 2014 through 2018. Our final data set includes standard and complaint surveys, associated deficiencies, and associated enforcement actions for all 50 States and the District of Columbia.

We analyzed trends in deficiencies associated with facility-initiated discharges from 2014 through 2018. We analyzed these data to determine the number and percentage of deficiencies that were related to facility-initiated discharge over time and across States. We determined the number of deficiencies associated with a facility-initiated discharge by calculating the total number of each deficiency type listed in CMS's December 2017 memo. To determine the percentage of nursing homes cited for a deficiency associated with a facility-initiated discharge, we used the number of nursing homes surveyed for each year. We also examined trends in each type of deficiency over time.

Interviews With State Ombudsmen

We conducted structured interviews with a purposive sample of five State Ombudsmen in October and November 2020. We selected the sample of State Ombudsmen to provide variation in geography and in State size. We also selected our sample based on information received from our 2019 survey to State Ombudsmen. During the interviews, we asked the State Ombudsmen about facility-initiated discharges during the COVID-19 pandemic. Specifically, we asked about the effect of COVID-19 on facility-initiated discharges; how Ombudsmen addressed inappropriate facility-initiated discharges during the COVID-19 pandemic; and challenges that Ombudsmen faced with addressing these discharges during the COVID-19 pandemic. We analyzed these interviews to identify themes.

Interviews With CMS ROs

We conducted structured interviews with all 10 CMS ROs in July 2019. We asked CMS ROs about their implementation of CMS's December 2017 memo. Specifically, we asked CMS ROs about the number of cases that State agencies transferred as a result of the memo and the CMS ROs' review process for these cases. We also asked CMS ROs about their communication with State agencies and Ombudsmen in their regions. Finally, we asked CMS ROs about their experiences and challenges with addressing inappropriate facility-initiated discharges. We categorized the interview data to identify themes across ROs.

Interviews With CMS Headquarters and ACL

We also conducted interviews with CMS Headquarters staff and ACL staff. We conducted multiple interviews with CMS and ACL separately from 2018 through 2020.

We asked about each agency's efforts to address inappropriate facility-initiated discharges and about challenges they face in doing so, among other questions. We used these interviews to report on CMS's and ACL's efforts and to provide clarification and context.

In addition, we interviewed CMS and ACL staff about the impact of the COVID-19 pandemic on facility-initiated discharges. We conducted these interviews in October and November 2020. We asked CMS and ACL about how they addressed inappropriate facility-initiated discharges and about challenges in addressing these discharges during the COVID-19 pandemic, among other questions.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: October 5, 2021

TO: Christi A. Grimm
Principal Deputy Inspector General
Office of Inspector General

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

SUBJECT: Office of Inspector General (OIG) Draft Report: Facility-Initiated Discharges in Nursing Homes Require Further Attention (OEI-01-18-00250)

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 enforcing long-term care (LTC) requirements, including those to prevent inappropriate discharges, and has worked to ensure health care facilities have the tools and flexibilities they need to respond to COVID-19, while maintaining patient and resident safety. Federal regulations governing LTC facilities provide many protections for all nursing home residents, including the right to remain in the facility, and not be transferred or discharged, except in a limited set of circumstances, including when the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility (42 C.F.R. § 483.15(c)(1)). Nursing homes must document all facility-initiated discharges in the resident's medical record and provide adequate notice to the resident. Documentation in the resident's medical record should include a discharge care plan and documented discussions with the resident or resident's representative regarding discharge planning and post-discharge care.

Nursing homes routinely discharge residents safely and appropriately, however, to ensure nursing homes are in compliance with federal requirements, CMS provides ongoing oversight of nursing homes through certification and complaint surveys conducted by State Survey Agencies (SSAs). To assist SSAs in the survey process, in November 2017, CMS revised interpretive guidance to address discharges that would violate federal requirements, and directed surveyors to investigate fully to determine whether a discharge is in accordance with the resident's and/or resident representative's wishes and complies with federal requirements.[1] Subsequently, CMS released a survey and certification memorandum, S&C-18-08-NH, in December 2017, announcing an initiative to address inappropriate discharges through a number of new actions.[2] The initiative directed SSAs to transfer to CMS any case involving facility-initiated discharge

[1] 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, https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R173SOMA.pdf.

[2] An Initiative to Address Facility Initiated Discharges that Violate Federal Regulations, Ref: S&C 18-08-NH (Dec. 22, 2017), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-18-08.pdf.

violations where there is a discharge to a questionable or unsafe setting, where residents remain hospitalized (because the nursing home will not permit the resident to return), where there is a facility pattern of inappropriate discharges, or other circumstances that CMS may identify. Following the review of such cases, CMS may take enforcement action for identified noncompliance, including imposing civil monetary penalties (CMP), when appropriate. In addition, CMS encouraged states to use the CMP Reinvestment Program 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 is also examining 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 SSAs, and evaluating enforcement options for these types of violations.

The Office of the State LTC Ombudsman also plays an important role in addressing concerns with inappropriate discharges. CMS regulations require facilities to provide immediate access to any resident by any representative of an Office of the State LTC Ombudsman (42 C.F.R. § 483.10(f)(4)(i)). CMS also requires that facilities send a copy of each transfer or discharge notice to the Office of the State LTC ombudsman (42 C.F.R § 483.15(c)(3)). Such notice explains the transfer or discharge and the reason for the move in writing, and must be supplied to the resident and the resident's representative(s) before a facility transfers or discharges a resident, and in a language and manner they understand. Facilities that do not comply with these and all other requirements are subject to deficiency citation and enforcement action.

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

Recommendations to CMS:

OIG Recommendation

Provide training for nursing homes on federal requirements for facility-initiated discharge notices

CMS Response

CMS concurs with OIG's recommendation. CMS is committed to preventing inappropriate facility-initiated discharges in nursing homes, and will make training available on federal requirements related to facility-initiated discharge notices to all Long-Term Care stakeholders.

OIG Recommendation

Assess the effectiveness of its enforcement of inappropriate facility-initiated discharges

CMS Response

CMS concurs with OIG's recommendation. CMS is committed to enforcing our discharge requirements to prevent inappropriate discharges and will assess the effectiveness of our

enforcement actions imposed in noncompliant facility-initiated discharge cases within the broader context of our oversight priorities and resources. CMS notes, however, that implementation of this recommendation will depend on the public health emergency and limited resources. Additionally, as with any evaluation, it may take several subsequent survey cycles to accurately assess the effectiveness of our enforcement.

OIG Recommendation
Implement its deferred initiatives to address inappropriate facility-initiated discharges

CMS Response
CMS concurs with OIG's recommendation. CMS's long-term initiatives to address inappropriate facility-initiated discharges were paused during the COVID-19 pandemic to focus its resources on urgent patient and resident safety needs that arise during the public health emergency. CMS continues to evaluate facility-initiated discharge issues in nursing homes and plans to implement a variety of interventions, including those that were previously planned, as soon as is possible.

Recommendations to CMS and ACL:

OIG Recommendation
Coordinate to strengthen safeguards to protect nursing home residents from inappropriate facility-initiated discharges

CMS Response
CMS and ACL are committed to coordinating to strengthen safeguards to protect nursing home residents from inappropriate facility-initiated discharges. CMS and ACL will continue to work closely with our colleagues and other nursing home advocates regularly to address concerns regarding inappropriate discharges.

OIG Recommendation
Ensure that all State Ombudsmen, State agencies, and CMS ROs have an ongoing venue to share information about facility-initiated discharges and potentially other systemic problems in nursing homes

CMS Response
CMS and ACL concur with OIG's recommendation. CMS and ACL will continue to work closely with our partners to ensure there is an ongoing venue to share information about facility-initiated discharges and potentially other systemic problems in nursing homes.

APPENDIX A: AGENCY COMMENTS

Improving the Lives of Older Adults and People with Disabilities Through Services, Research, and Education

DATE: October 8, 2021

TO: Christi A. Grimm
Principal Deputy Inspector General
Office of Inspector General

FROM: Alison Barkoff
Acting Administrator & Assistant Secretary for Aging
Administration for Community Living

SUBJECT: Office of Inspector General (OIG) Draft Report: Facility-Initiated Discharges in Nursing Homes Require Further Attention OEI-01-18-00250

The Administration for Community Living (ACL) appreciates the opportunity to respond to the Office of the Inspector General's (OIG) report on facility-initiated discharges in nursing homes.

ACL shares the OIG's concerns about the harms that can be caused by inappropriate discharges, and addressing them are a significant focus for the Long-Term Care Ombudsman (LTCO) program. As the OIG's report notes, facility-initiated discharges are the most common complaints addressed by LTCO programs.

Facility-initiated discharges in nursing homes also are a significant focus of the National Ombudsman Resource Center (NORC), which is funded by ACL through a cooperative agreement to provide technical assistance to state LTCO programs. Through the NORC, LTCOs and their representatives have access to a number of tools and resources, as well as training, to help them address inappropriate discharges – both for individual residents and at the facility and system levels.

For example, in January 2021, the NORC published a primer on the issue, *Enhancing Your Advocacy Toolbox: Protecting Residents from Nursing Facility-Initiated Discharges.* This resource covers federal requirements and guidance for state survey agencies, as well as action steps to help LTCO programs address common issues related to facility-initiated discharges. The NORC also has presented several training courses, which also can be downloaded for LTCO programs to use with their staff; shared information about promising practices and presentations that are available for download; created materials to help educate residents; and more.

The NORC has aggregated these resources in a dedicated section of its website. Also included are resources provided by CMS, such as this memo from CMS to state survey agency directors, which describes CMS's initiative to examine and mitigate facility-initiated discharges that violate federal regulations, and this Survey and Certification memo from 2017, that clarifies requirements for sharing discharge notices with the state LTCO.

ACL also supports CMS in developing guidance for state survey agencies about issues encountered by LTCO programs and the nursing home residents they support.

ACL appreciates the attention that the OIG has given to this important issue and looks forward to working with OIG on this and other matters in the future. OIG's recommendations and ACL's response are below.

Recommendations for ACL:

OIG Recommendation 1
Assist State Ombudsman programs in establishing a data collection system for facility-initiated discharge notices.

ACL Response:
ACL concurs with this recommendation. ACL supports data collection to assist the LTCO program in each state in upholding the rights of nursing facility residents. Through the National Ombudsman Resource Center, ACL will continue to provide state LTCO programs with technical assistance to help them establish systems to count and extract information from facility-initiated discharge notices. Because each state has different needs, staffing capacity, and software to capture data, the approach for capturing data will vary between states.

OIG Recommendation 2
Establish guidance for analysis and reporting of data collected by State Ombudsman programs from facility-initiated discharge notices.

ACL Response:
ACL concurs with this recommendation. ACL agrees that analysis of data can reveal patterns of inappropriate discharges that can inform the programs' advocacy work; in fact, it often does.

State ombudsman programs currently record and report information about the complaints they receive from residents, including complaints about facility-initiated discharges, through ACL's National Ombudsman Reporting System (NORS). With that information, they regularly identify systemic issues they can address.

For example, noting large numbers of resident complaints about discharge notices based on non-payment, the LTCO in Alabama discovered that resident and family misunderstanding of Medicaid requirements were causing delayed approval and payments to nursing homes, putting residents at risk of involuntary discharge. The Ombudsman was then able to resolve the issue by working with the state Medicaid agency, facility associations and individual facilities. Information on that issue was reported through NORS, enabling the NORC to share the lessons learned with LTCO programs across the country.

Similarly, it was analysis of complaint data that led LTCO programs to identify facility-initiated discharges as a systemic problem and to raise concerns with ACL and CMS. Those concerns ultimately led to the requirement for nursing facilities to send discharge notices to the LTCO to create an opportunity for timely intervention when residents object to the discharge or have

questions about their options. This has proven successful; in 2020, Ombudsman programs were able to fully or partially resolve 73 percent of complaints about facility-initiated discharges and 17 percent of complaints were withdrawn. Only 10 percent were not resolved to the full or partial satisfaction of the discharged resident.

In recent years, the NORC has provided a number of training and resources to support LTCO programs in addressing involuntary discharges, and the importance of discharge notices is included. For example, the primer described above includes a checklist for investigating complaints that highlights the discharge notice as a key source of information. ACL will continue to work with states and the NORC to provide guidance, training, and technical assistance to support LTCO programs in assessing and tracking information included in discharge notices to enable that crucial analysis.

ACL also will engage with state LTCO programs to determine whether there is additional information that could be gleaned from facility discharge notices that would assist them in responding to complaints and/or advocating at the system level. If so, ACL will explore options for modifying the NORS system to collect such data when resources become available. In addition, ACL will explore possibilities for incorporating additional information about discharge notices into existing data collection systems.

In addition, ACL will engage with state LTCO programs to identify barriers to data collection and analysis and possible options for overcoming them. For example, some nursing homes routinely send all discharge notices to the state LTCO, not only the notices that are required by CMS regulations. The office of the Pennsylvania LTCO reported that in one month, it received more than 5,000 discharge notices, only 26 of which were involuntary discharges. Reviewing each of those notices to find the few that may require the assistance of the LTCO program consumes significant staff time; recording and reporting on all of them would be an administrative burden that would significantly degrade the Ombudsman's ability to meet its statutory responsibilities.

Similarly, the LTCO's role in facility-initiated discharges is primarily focused on discharges to which the resident objects – whether or not the discharge notification complied with requirements or the discharge itself is appropriate. A resident may request assistance with a facility-initiated discharge, even if the discharge fully complied with requirements. On the other hand, if a resident does not object to a facility-initiated discharge, the LTCO may not be involved even if the discharge notification was not handled properly. Recording, reporting, and analyzing data from facility notices that do not require assistance from the Ombudsman also will require diversion of staff time from direct support to residents and advocacy activities.

Finally, ACL will provide to CMS all data on involuntary discharges reported annually through NORS to inform CMS's development of training and guidance for state survey agencies about issues encountered by LTCO programs and the nursing home residents they support.

Recommendations for ACL and CMS:

OIG Recommendation 1

Coordinate to strengthen safeguards to protect nursing home residents from inappropriate facility-initiated discharges.

ACL Response

ACL will continue to work with CMS, state long-term care LTCO programs, state protection and advocacy agencies, older adults and people with disabilities, and other stakeholders to address concerns and explore strategies regarding inappropriate discharges.

OIG Recommendation 2

Ensure that all State Ombudsmen, State agencies, and CMS ROs have an ongoing venue to share information about facility-initiated discharges and potentially other systemic problems in nursing homes.

ACL Response

ACL concurs with this recommendation. ACL will continue to work with CMS to ensure regular dialogue between CMS regional offices, long-term care Ombudsmen, state survey agencies and other partners.

ACKNOWLEDGMENTS AND CONTACT

Acknowledgments

Kimberly Ruppert served as the team leader for this study, and Shanna Weitz served as the lead analyst. Others in the Office of Evaluation and Inspections who conducted the study include Shweta Palakkode and Malaena Taylor. Office of Evaluation and Inspections staff who provided support include Joe Chiarenzelli, Kevin Farber, and Christine Moritz.

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 and Ken Price, Deputy Regional Inspectors General.

Contact

To obtain additional information concerning this report, contact the Office of Public Affairs at Public.Affairs@oig.hhs.gov. OIG reports and other information can be found on the OIG website at oig.hhs.gov.

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

ABOUT THE OFFICE OF INSPECTOR GENERAL

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These audits help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

ENDNOTES

[1] CMS regulations refer to both facility-initiated discharges and transfers from nursing homes. Transfer specifically refers to the movement of a resident from one certified facility to another when the resident expects to return to the original facility. In contrast, discharge specifically refers to the movement of a resident from a certified facility to another certified facility or other location in the community when there is no expectation of return to the original facility (42 CFR 483.15; CMS, *SOM*, Appendix PP Tag 622). This report will examine only facility-initiated discharges.

[2] Congress.gov, H.R. 3545–Omnibus Budget Reconciliation Act of 1987. Accessed at https://www.congress.gov/bill/100th-congress/house-bill/3545 on September 25, 2020.

[3] National Ombudsman Reporting System, Appendix B. Accessed at https://www.acl.gov/programs/long-term-care-Ombudsman/ltc-Ombudsman-national-and-state-data on October 20, 2020.

[4] National Ombudsman Reporting System 2016 Multi-Year Complaint Trends Report. Accessed at http://ltcOmbudsman.org/omb_support/nors/nors-data on May 8, 2018.

[5] CMS, "*An Initiative to Address Facility Initiated Discharges That Violate Federal Regulations*." S&C 18-08-NH, December 22, 2017.

[6] Sedensky, Matt. "Nursing Homes Turn to Eviction To Drop Difficult Patients," *Associated Press*. Accessed at https://apnews.com/95c33403b5024b4380836d3ed3dfecb0/nursing-homes-turn-eviction-drop-difficult-patients May 8, 2016.

[7] The New York Times, *'They Just Dumped Him Like Trash': Nursing Homes Evict Vulnerable Residents,* June 21, 2020. Accessed at https://www.nytimes.com/2020/06/21/business/nursing-homes-evictions-discharges-coronavirus.html on November 5, 2020.

[8] CMS, *State Operations Manual (SOM),* Appendix PP (Rev. 11-22-17), Tag 622.

[9] CMS, *SOM,* Appendix PP, Tag 622.

[10] 42 CFR § 483.15(c)(2)(i)-(ii).

[11] 42 CFR § 483.15(c)(2)(i)(B).

[12] Nursing homes must send the discharge notice as soon as practicable before transfer or discharge in certain circumstances, which are: the endangerment of the health or safety of individuals in the facility, a sufficient improvement in the resident's health to allow for a more immediate transfer or discharge, an immediate transfer or discharge is required by the resident's urgent medical needs, or the resident has not resided in the facility for 30 days (see 42 CFR §483.15(c)(4)).

[13] 42 CFR § 431.220(a)(2).

[14] 42 CFR § 431.206(b)(3).

[15] 42 CFR § 431.206(b)(3).

[16] 42 CFR § 431.246.

[17] 42 CFR § 483.15(c)(5)(iv).

[18] 42 CFR § 483.15(c)(5)(iv).

[19] 42 CFR § 483.15(c)(1)(ii).

[20] Sections 1819 and 1919 of the Social Security Act.

[21] 42 CFR §488.308

[22] Sections 1819(g)(4)(A) and 1919(g)(4)(A) of the Social Security Act.

[23] CMS, *SOM* Chapter 5–Complaint Procedures (Rev. 191, 07-19-19), 5300.1.

[24] CMS, *SOM Appendix PP–Guidance to Surveyors for Long-Term Care Facilities* (Rev. 11-22-17).

[25] In 2017, CMS revised its list of deficiencies for nursing homes and combined the deficiency for transfer and discharge requirements under one deficiency. Previously, two deficiencies related to transfer and discharge requirements: basis for transfer or discharge of residents and documentation for transfer or discharge of residents.

[26] 42 CFR §488.402(d)(1)

[27] CMS, *SOM*, Chapter 7 7304.4; this section was updated and moved to section 7317, effective Nov. 16, 2018 (Rev. 185).

[28] CMS, *SOM*, Chapter 7.

[29] CMS, *SOM*, Chapter 7–Enforcement Action when Immediate Jeopardy Exists (Rev. 185, 11-16-18), 7308.

[30] CMS, *SOM,* Chapter 7 7400.4 (Rev. 185, 11-16-19).

[31] In February 2020, CMS changed its internal structure to allow for better coordination between CMS ROs (now known as CMS-Locations) and the CMS Central Office (now known as the Quality, Safety, and Oversight Group). According to CMS, this reorganization brings CMS staff who develop enforcement policies and staff who implement these policies under the same organizational leadership to help ensure consistency.

[32] CMS, "*An Initiative To Address Facility Initiated Discharges that Violate Federal Regulations*." S&C 18-08-NH, December 22, 2017.

[33] ACL, *Program Areas: Protecting Rights and Preventing Abuse.* Accessed at https://acl.gov/programs/protecting-rights-and-preventing-abuse on May 10, 2021.

[34] ACL, *Older Americans Act,* Accessed at https://acl.gov/about-acl/authorizing-statutes/older-americans-act

[35] 42 U.S. Code § 3058g—State Long-Term Care Ombudsman program.

[36] *Ibid.*

[37] 45 CFR parts 1321 and 1324.

[38] The National Long-Term Care Ombudsman Resource Center, *National Ombudsman Reporting System (NORS)*, Accessed at https://ltcOmbudsman.org/omb_support/nors on September 25, 2020.

[39] The National Long-Term Care Ombudsman Resource Center, *Introduction to the Revised National Ombudsman Reporting System (NORS)*, Accessed at https://ltcOmbudsman.org/uploads/files/support/NORS_February_5_2019_webinar_-_FINAL_w_notes.pdf on September 25, 2020.

[40] ACL revised the NORS data collection strategy on October 1, 2019 (see endnote 20). The revised guidance requires Ombudsmen to provide specific data for cases and complaints rather than aggregate data reporting as in the past. (See ACL, *Introduction: Moving From Aggregated to Case Record Data;* accessed at https://acl.gov/sites/default/files/about-acl/2018-02/Introduction%20to%20Revised%20NORS%20.pdf on September 25, 2020.)

[41] 42 CFR § 483.15(c)(3)(i).

[42] 81 Federal Register 68688, 68734 (Oct. 4, 2016).

[43] CDC, *Coronavirus Disease 2019 (COVID-19) Symptoms of Coronavirus*. Accessed at https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html on October 7, 2020.

[44] National Public Radio, *How COVID-19 Kills: The New Coronavirus Disease Can Take a Deadly Turn.* Accessed at https://www.npr.org/sections/goatsandsoda/2020/02/14/805289669/how-covid-19-kills-the-new-coronavirus-disease-can-take-a-deadly-turn, on October 7, 2020.

[45] CMS, *COVID-19 Nursing Home Data*, submitted data as of week ending April 4, 2021. Accessed at https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg/ on April 19, 2021.

[46] The White House, *Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak*, March 13, 2020. Accessed at Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak–The White House (archives.gov) on October 8, 2020.

[47] CMS, *COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers*. Accessed at COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers (cms.gov) on May 10, 2021.

[48] I*bid.* This waiver has since been terminated, effective May 10, 2021.

[49] CMS, Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes (Revised), QSO-20-14-NH, March 13, 2020.

[50] CMS, *Nursing Home Five-Star Quality Rating System updates, Nursing Home Staff Counts, Frequently Asked Questions, and Access to Ombudsmen (REVISED)*, QSO-20-28-NH, April 24, 2020 (revised July 9, 2020, and updated September 28, 2020, and March 10, 2021).

[51] CMS, *Nursing Home Visitation–COVID-19,* QSO-20-39-NH, September 17, 2020.

[52] CMS, *Nursing Home Visitation*–COVID-19 (REVISED), QSO-20-39-NIH, revised March 10, 2021 (subsequently revised April 27, 2021).

[53] OIG, *Nursing Home Oversight During the COVID-19 Pandemic*. Accessed at https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000473.asp on November 5, 2020.

[54] OIG, *Some Nursing Homes' Reported Staffing Levels in 2018 Raise Concerns; Consumer Transparency Could Be Increased.* Accessed at https://oig.hhs.gov/oei/reports/OEI-04-18-00450.pdf on September 25, 2020.

[55] OIG, *States Continued to Fall Short in Meeting Required Timeframes for Investigating Nursing Home Complaints: 2016-2018,* OEI-01-19-00421, September 2020. Accessed at https://oig.hhs.gov/oei/reports/OEI-01-19-00421.asp?utm_source=web&utm_medium=web&utm_campaign=nh-trends-OEI-01-19-00421 on January 11, 2021.

[56] OIG Work Plan, *Nursing Homes: CMS Oversight of State Survey Agencies,* OEI-06-19-00460.

[57] In its October 2016 Final Rule, CMS stated that the requirement for nursing homes to send a copy of the facility-initiated discharge notice to the State Ombudsmen will "provide added protection to the resident and assist the State Ombudsman to keep informed of facility activities" (see 81 Federal Register 68688, 68734; October 4, 2016).

[58] NORS includes a complaint category for "discharge or eviction" but does not include a specific category for complaints directly related to facility-initiated discharges.

[59] 42 CFR § 431.246.

[60] The timeframe in which residents must file for an administrative hearing varies by State, but CMS requires that this not exceed 90 days (see 42 CFR § 431.221(d)).

[61] Deficiencies with "notice requirements before transfer or discharge" includes both facility-initiated discharges and transfers.

[62] In February 2020, CMS restructured its Regional Offices (now CMS-Locations) to increase consistency in enforcement actions.

[63] OIG Work Plan, *Nursing Homes' Compliance With Facility-Initiated Discharge Requirements,* OEI-01-19-00251. Accessed at https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000541.asp.