

Aging Forum Report Appendix

Feedback Request for Crisis Issues for the Aging Forum

Consider the following scenario and respond to the following questions accordingly:

- a) If you were involved in this scenario, what types of issues or problems might you encounter?**
- b) What types of responses/models are you aware of that would assist with a case like this?**

An elderly woman with dementia has been at the same nursing home for 2 years. She is becoming increasingly combative and recently attempted to choke her room-mate. During times she is combative she appears to be hallucinating and agitated about things that happened in her past, specifically when she was living in Europe during WWII. Due to this behavior, the police are called and an emergency detention is requested. She is sent to a locked psychiatric unit.

The family of the woman is displeased with this because their father had been sent to a locked psychiatric facility in the past and it was a very negative experience for their father and for them. While the woman is on the psychiatric unit, she refuses to go to groups and is quite sedated from the new psych meds. The psychiatrist would like her hold to be transferred to a Chapter 55 from a Chapter 51. However, before that can happen, she is transferred to the medical unit because her ankles are swollen. It is determined that her swollen ankles are due to one of the psych meds she is on. When she is medically stable, the psych unit refuses to take her back, recommending the Chapter 55 once again.

The nursing home refuses to take her back based upon the history. In the meantime, since she is medically stable, the hospital is pressuring the family that the woman be discharged immediately.

We have provided this scenario to provide some context for you to share your perspective, but feel free to make general comments about crisis issues for the aging and the ability of the system to respond.

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Attached are portions of applicable State and federal statutes and regulations, some of which are presented below. Emphasis with underlining has been added.

General Response:

This scenario is all too familiar to some staff who work in the Department of Health and Family Services. The scenario points out system failures by the county, hospital, and the nursing home (note: this response also pertains to other provider types, such as adult family homes and community based residential facilities). Each of the entities has responsibilities under various statutes and regulations. Often the responsibilities are shared and the responsibilities are not predicated on who is receiving reimbursement for the care and treatment of the person. Therefore, none of the entities should be shirking their duties and saying that it is someone else's problem to resolve.

Responsibilities of the nursing home:

It is likely that the nursing home has failed to meet several federal nursing facility requirements (discussed in the numerical order of the regulations).

1. 42 CFR 483.12(a)(2). An involuntary discharge would be permitted for this scenario if the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility or the safety of individuals in the facility is endangered. The phrase, "medically stable," is nonspecific. Without clarification, it is not clear if the woman remains a danger to others or if her challenging behaviors could be safely and appropriately managed within a nursing facility. Therefore, there is not support for a conclusion that an involuntary discharge is necessary and appropriate. However, it is appropriate for the nursing home to ask the hospital for clarification of the meaning of "she is medically stable." What are the frequency, duration and severity of her mental illness symptoms and challenging behaviors? Over what period of time? What treatment methods have been provided to her? Can the treatment methods be replicated in the nursing home (e.g., use of restraints cannot be used on an ongoing basis)? Are there environmental or staffing differences that can or cannot be replicated in the nursing home? The answers to these questions will help determine when it might be appropriate for the nursing home to have the woman return.
2. 42 CFR 483.12(a)(7). The facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. Given that a hospital is not a residence (i.e., a place of fixed habitation), a nursing home should not be discharging a person to a hospital; to do so is prima facie evidence that the facility has failed to meet this requirement. Nursing facilities should view this type of situation as a transfer, not a discharge.

3. 42 CFR 483.20(b). The facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. Among the areas that the assessment must include are mood and behavior patterns; psychosocial well-being; and medications. Nursing facility staff understand that in order to appropriately meet the needs of a person who has pneumonia that they will need information that goes beyond the diagnosis. For example, it is important to know if the person has had a temperature and, if so, for how long and the response to medication and other interventions. However, nursing facilities (as well as other provider types) often fail to make reasonable efforts to obtain the relevant data behind mental illness diagnoses and use of psychotropic medications. The staff should be asking for information from the person's primary care physician, the person, or his/her family members for details about the specific symptoms/behaviors that have been observed; the frequency, severity and duration of the symptoms/behaviors; the circumstances in which the symptoms/behaviors are mostly likely to occur; the manner in which the symptoms/behaviors affect the person's functioning (e.g., interpersonal functioning, ability to work or complete tasks, etc.); and the interventions that previously helped to decrease the symptoms/behaviors and increase the level of independent functioning. This information is essential to develop an appropriate, individualized care plan.

In this particular case, it would be appropriate to ask family members what they know of her experiences during World War II and why her father was hospitalized (i.e., was this for reasons other than a mental illness?); if she has had any prior symptoms of post-traumatic stress disorder (PTSD); and if she has had prior treatment for PTSD and, if so, what type of treatment and how did she respond to the treatment. Given that she has a diagnosis of dementia, is she oriented to place and time? If not, then is she truly hallucinating, having flashbacks (a symptom of PTSD), or confused about where and when she is? While she may have dementia, are the behaviors and her confusion exacerbated by a treatable medical condition (e.g., urinary tract infection, medication side effect/drug interactions)?

If the facility staff do not have the knowledge and skills necessary to complete an appropriate assessment of this person's psychosocial functioning, then the facility must obtain consultation from a professional who can perform an appropriate assessment. In this particular case, the facility at the time of the transfer to the hospital should communicate to hospital staff and attending physician the need for an appropriate assessment and treatment recommendations for the care plan.

Note: It is not always possible to obtain an answer for every assessment question. If a set of treatment approaches results in a decrease in the identified symptoms and an increase in the person's ability to function as independently as possible, then it may not be necessary to answer all assessment questions. At the same time, it is important to acknowledge that facility staff often have more information that is significant for understanding issues related to psychiatric symptoms and challenging behaviors than is documented. A mental health professional should be interested in eliciting such information from staff as part of an assessment.

4. 42 CFR 483.20(k). The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's

highest practicable physical, mental, and psychosocial well-being as required under § 483.25; and the services provided or arranged by the facility must meet professional standards of quality and be provided by qualified persons in accordance with each resident's written plan of care. In this example, it is unlikely that the facility has documentation that demonstrates their efforts in this area.

5. 42 CFR 483.25. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This section includes more specific language under par. (f): Based on the comprehensive assessment of a resident, the facility must ensure that (1) A resident who displays mental or psychosocial adjustment difficulty, receives appropriate treatment and services to correct the assessed problem, and (2) A resident whose assessment did not reveal a mental or psychosocial adjustment difficulty does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that such a pattern was unavoidable. In this example, it is unlikely that the facility has documentation that demonstrates their efforts in this area.
6. 42 CFR 483.25(l). Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: (i) In excessive dose (including duplicate drug therapy); or (ii) For excessive duration; or (iii) Without adequate monitoring; or (iv) Without adequate indications for its use; or (v) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (vi) Any combinations of the reasons above. In this particular case, the facility should communicate to hospital staff and attending physician the need for an appropriate assessment and treatment recommendations for the care plan. While the hospital may claim that the person is not exhibiting challenging behaviors, it would seem that this outcome may have been achieved using treatment approaches that are not permitted within a nursing facility (i.e., the woman "is quite sedated from the new psych meds"). In addition, the hospital transferred her to a medical unit because the psychotropic medications caused her ankles to swell, which appears to be an acknowledgement that the medication regimen needs to be changed. Therefore, it is reasonable for the facility to communicate to the hospital that a transfer back to the facility is not appropriate until this issue is better addressed.
7. 42 CFR 483.30. The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.
8. 42 CFR 483.45. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must (1) Provide the required services; or (2) Obtain the required services from an outside resource (in accordance with § 483.75(h) of this part) from a provider of specialized rehabilitative services.

Note: Facilities should review the memo addressing specialized psychiatric rehabilitation services: http://dhfs.wisconsin.gov/dsl_info/NumberedMemos/DDES/CY_2004/NMemo2004-18-DDES.htm. In particular, the last paragraph of the memo states, "Currently, some nursing facilities categorically refuse to admit any person who requires specialized services, which is permitted under federal Medicaid regulations because the state, not a nursing facility, is responsible for the provision of specialized services. However, the federal Medicaid

regulations identify the nursing facility as responsible for providing "services of a lesser intensity" or specialized psychiatric rehabilitative services. **A nursing facility is permitted to refuse to admit or involuntarily relocate an individual whose needs cannot be met by the nursing facility, but this must be done based on an assessment of the individual's needs and an assessment of the facility's capacity (i.e., knowledge, skills, and resources) to meet the individual's needs.**"

Responsibilities of the hospital:

Hospitals do not have the same level of specificity regarding assessment and care planning that nursing homes have. While the hospital may claim that the person is not exhibiting challenging behaviors, it would seem that this outcome may have been achieved using treatment approaches that are not permitted within a nursing facility (i.e., the woman "is quite sedated from the new psych meds"). In addition, the hospital transferred her to a medical unit because the psychotropic medications caused her ankles to swell, which appears to be an acknowledgement that the medication regimen needs to be changed. Standards of practice for health care professionals may address some of these issues beyond the hospital regulations.

Note: The term, "medically stable" only indicates that the person's condition is not deteriorating. The term is not a particularly useful term because the term does not indicate the status of the person's condition. For example, a person who is on an intensive care unit can be described as medically stable, but still in a critical condition.

Note: The psychiatric unit refused to take her back, recommending the transfer from an involuntary commitment to a protective placement order. The revised State statutes related to protective placement (s. 55.15) make it clear that a ward may not be transferred, under the protective placement order, to any facility for which commitment procedures are required (i.e., a psychiatric unit); such a transfer would have to be made as a voluntary admission under s. 51.10 for which the person agrees or does not protest.

Also, without adequate assessment and the achievement of some treatment objectives, a hospital may retain some liability if a person who was discharged experiences an adverse outcome soon after discharge. If the hospital staff are interested in decreasing potential liability, they should at a minimum, evaluate the capacity of a provider, whether it is the original, a different nursing home, or other provider, to meet a person's needs. Physicians and hospital staff need to understand that a person who no longer requires inpatient hospitalization is not the same as being appropriate for admission to a particular provider type.

The hospital does not appear to have made bona fide efforts regarding the following federal requirements (only excerpts are shown):

42 CFR 482.43. Condition of participation: Discharge planning. The hospital must have in effect a discharge planning process that applies to all patients. The hospital's policies and procedures must be specified in writing.

(a) Standard: Identification of patients in need of discharge planning. The hospital must identify at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning.

(b) Standard: Discharge planning evaluation.

(1) The hospital must provide a discharge planning evaluation to the patients identified in paragraph (a) of this section, and to other patients upon the patient's request, the request of a person acting on the patient's behalf, or the request of the physician.

- (2) A registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise the development of, the evaluation.
- (3) The discharge planning evaluation must include an evaluation of the likelihood of a patient needing post-hospital services and of the availability of the services.
- (4) The discharge planning evaluation must include an evaluation of the likelihood of a patient's capacity for self-care or of the possibility of the patient being cared for in the environment from which he or she entered the hospital.
- (5) The hospital personnel must complete the evaluation on a timely basis so that appropriate arrangements for post-hospital care are made before discharge, and to avoid unnecessary delays in discharge.
- (6) The hospital must include the discharge planning evaluation in the patient's medical record for use in establishing an appropriate discharge plan and must discuss the results of the evaluation with the patient or individual acting on his or her behalf.
- (c) *Standard: Discharge plan.* (1) A registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise the development of, a discharge plan if the discharge planning evaluation indicates a need for a discharge plan.
- (2) In the absence of a finding by the hospital that a patient needs a discharge plan, the patient's physician may request a discharge plan. In such a case, the hospital must develop a discharge plan for the patient.
- (3) The hospital must arrange for the initial implementation of the patient's discharge plan.
- (4) The hospital must reassess the patient's discharge plan if there are factors that may affect continuing care needs or the appropriateness of the discharge plan.
- (5) As needed, the patient and family members or interested persons must be counseled to prepare them for post-hospital care.
- (d) Standard: Transfer or referral. The hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for followup or ancillary care.
- (e) *Standard: Reassessment.* The hospital must reassess its discharge planning process on an on-going basis. The reassessment must include a review of discharge plans to ensure that they are responsive to discharge needs.

Responsibilities of the county:

The county has statutory responsibilities related to the emergency detention. Depending on the disposition of the emergency detention (i.e., if a court order for involuntary commitment under s. 51.20 was granted or a conversion to court orders for guardianship under and protective placement under Chs. 54 and 55), the county has a general responsibility to arrange for treatment and placement in the least restrictive manner consistent with the person's needs and the court order. In this example, it is important to acknowledge that the county does not have a lot of incentive to take the lead in this matter for a couple of reasons. First, it is unlikely that the county is paying for the hospitalization. If she is a Medicaid recipient and she is at least 65 years of age, then Medicaid will pay for her hospitalization; otherwise, Medicare and her private insurance or assets may be available. Second, while she is in the hospital or nursing home, county staff generally consider the person to be in a place in which she is safe and capable of providing appropriate care and treatment. Therefore, the county staff are likely to accept direction from the hospital and nursing home staff regarding recommendations for placement and the timing of the discharge from the hospital. As stated above, if an adverse outcome occurs, then the county may have some liability exposure if the placement decisions were not reasonable and appropriate given the data about the person's needs.

General recommendations for novel and challenging situations:

Request review(s) by parties outside of the interdisciplinary treatment team, such as a hospital ethics committee, Board on Aging and Long Term Care Ombudsman. Request review, technical assistance

and direction DHFS staff from Area Administration, the Division of Quality Assurance, program staff (e.g., Bureau of Mental Health and Substance Abuse Services); these persons may have suggestions for assessment and care planning; facilitating discussions between the nursing facility, hospital and county; etc. In general, outside review will either confirm that reasonable and appropriate efforts are being made to meet the needs of the person and address the situation or provide suggestions to better meet the needs of the person and improve the situation. In either case, such efforts can help indemnify the facility/entity from citations, litigation or other adverse outcomes. When necessary, involve your corporation counsel and administration.

Pertinent State Nursing Home Regulations

HFS 132.33(3) PLACEMENT. (a) A resident may be housed in a locked unit under any one of the following conditions:

1. The resident consents under sub. (4) to being housed on a locked unit;
2. The court that protectively placed the resident under s. 55.06, Stats., made a specific finding of the need for a locked unit;
3. The resident has been transferred to a locked unit pursuant to s. 55.06 (9) (c), Stats., and the medical record contains documentation of the notice provided to the guardian, the court and the agency designated under s. 55.02, Stats.; or
4. In an emergency governed by sub. (5).

(b) A facility may transfer a resident from a locked unit to an unlocked unit without court approval pursuant to s. 55.06 (9) (b), Stats., if it determines that the needs of the resident can be met on an unlocked unit. Notice of the transfer shall be provided as required under s. 55.06 (9) (b), Stats., and shall be documented in the resident's medical record.

Pertinent State Statutes – Chapter 51, State Alcohol, Drug Abuse, Developmental Disabilities and Mental Health Act

51.01(10) “Inpatient facility” means a public or private hospital or unit of a hospital which has as its primary purpose the diagnosis, treatment and rehabilitation of mental illness, developmental disability, alcoholism or drug abuse and which provides 24-hour care.

51.01(19) “Treatment facility” means any publicly or privately operated facility or unit thereof providing treatment of alcoholic, drug dependent, mentally ill or developmentally disabled persons, including but not limited to inpatient and outpatient treatment programs, community support programs and rehabilitation programs.

51.20 Involuntary commitment for treatment. (1) PETITION FOR EXAMINATION. (a) Except as provided in pars. (ab), (am), (ar) and (av), every written petition for examination shall allege that all of the following apply to the subject individual to be examined:

1. The individual is mentally ill or, except as provided under subd. 2. e., drug dependent or developmentally disabled and is a proper subject for treatment.

2. The individual is dangerous because he or she does any of the following:
- a. Evidences a substantial probability of physical harm to himself or herself as manifested by evidence of recent threats of or attempts at suicide or serious bodily harm.
 - b. Evidences a substantial probability of physical harm to other individuals as manifested by evidence of recent homicidal or other violent behavior, or by evidence that others are placed in reasonable fear of violent behavior and serious physical harm to them, as evidenced by a recent overt act, attempt or threat to do serious physical harm. In this subd. 2. b., if the petition is filed under a court order under s. 938.30 (5) (c) 1. or (d) 1., a finding by the court exercising jurisdiction under chs. 48 and 938 that the juvenile committed the act or acts alleged in the petition under s. 938.12 or 938.13 (12) may be used to prove that the juvenile exhibited recent homicidal or other violent behavior or committed a recent overt act, attempt or threat to do serious physical harm.

c. Evidences such impaired judgment, manifested by evidence of a pattern of recent acts or omissions, that there is a substantial probability of physical impairment or injury to himself or herself. The probability of physical impairment or injury is not substantial under this subd. 2. c. if reasonable provision for the subject individual's protection is available in the community and there is a reasonable probability that the individual will avail himself or herself of these services, if the individual may be provided protective placement or protective services under ch. 55, or, in the case of a minor, if the individual is appropriate for services or placement under s. 48.13 (4) or (11) or 938.13 (4). The subject individual's status as a minor does not automatically establish a substantial probability of physical impairment or injury under this subd. 2. c. Food, shelter or other care provided to an individual who is substantially incapable of obtaining the care for himself or herself, by a person other than a treatment facility, does not constitute reasonable provision for the subject individual's protection available in the community under this subd. 2. c.

d. Evidences behavior manifested by recent acts or omissions that, due to mental illness, he or she is unable to satisfy basic needs for nourishment, medical care, shelter or safety without prompt and adequate treatment so that a substantial probability exists that death, serious physical injury, serious physical debilitation, or serious physical disease will imminently ensue unless the individual receives prompt and adequate treatment for this mental illness. No substantial probability of harm under this subd. 2. d. exists if reasonable provision for the individual's treatment and protection is available in the community and there is a reasonable probability that the individual will avail himself or herself of these services, if the individual may be provided protective placement or protective services under ch. 55, or, in the case of a minor, if the individual is appropriate for services or placement under s. 48.13 (4) or (11) or 938.13 (4). The individual's status as a minor does not automatically establish a substantial probability of death, serious physical injury, serious physical debilitation or serious disease under this subd. 2. d. Food, shelter or other care provided to an individual who is substantially incapable of obtaining the care for himself or herself, by any person other than a treatment facility, does not constitute reasonable provision for the individual's treatment or protection available in the community under this subd. 2. d.

e. For an individual, other than an individual who is alleged to be drug dependent or developmentally disabled, after the advantages and disadvantages of and alternatives to accepting a particular medication or treatment have been explained to him or her and because of mental illness, evidences either incapability of expressing an understanding of the advantages and disadvantages of accepting medication or treatment and the alternatives, or substantial incapability of applying an understanding of the advantages, disadvantages, and alternatives to his or her mental illness in order to make an informed choice as to whether to accept or refuse medication or treatment; and evidences a substantial probability, as demonstrated by both the individual's treatment history and his or her recent acts or omissions, that the individual needs care or treatment to prevent further disability or deterioration and a substantial probability that he or she will, if left untreated, lack services necessary for his or her health or safety and suffer severe mental, emotional, or physical harm that will result in the loss of the individual's ability to function independently in the community or the loss of cognitive or volitional control over his or her thoughts or actions. The probability of suffering severe mental, emotional, or physical harm is not substantial under this subd. 2. e. if reasonable provision for the individual's care or treatment is available in the community and there is a reasonable probability that the individual will avail himself or herself of these services or if the individual may be provided protective placement or protective services under ch. 55. Food, shelter, or other care that is provided to an individual who is substantially incapable of obtaining food, shelter, or other care for himself or herself by any person other than a treatment facility does not constitute reasonable provision for the individual's care or treatment in the community under this subd. 2. e. The individual's status as a minor does not automatically establish a substantial probability of suffering severe mental, emotional, or physical harm under this subd. 2. e.

51.20(13) DISPOSITION. (a) At the conclusion of the proceedings the court shall:

1. Dismiss the petition; or
2. If the subject individual is an adult, or is a minor aged 14 years or more who is developmentally disabled, proceed under s. 51.67 to determine whether the subject individual should receive protective placement or protective services; or
3. If the individual is not an inmate of a state prison, county jail or house of correction and the allegations specified in sub. (1) (a) are proven, order commitment to the care and custody of the appropriate county department under s. 51.42 or 51.437, or if inpatient care is not required order commitment to outpatient treatment under care of such county department; or

4. Omitted for this paper; or
5. If the allegations specified in sub. (1) (a) are proven and the subject individual is a nonresident, order commitment to the department.

(b) If the petition has been dismissed under par. (a), the subject individual may agree to remain in any facility in which he or she was detained pending the hearing for the period of time necessary for alternative plans to be made for his or her care.

(c) If disposition is made under par. (a) 3., all of the following apply:

1. The court shall designate the facility or service that is to receive the subject individual into the mental health system, subject to s. 51.06 (3).

2. The county department under s. 51.42 or 51.437 shall arrange for treatment in the least restrictive manner consistent with the requirements of the subject individual in accordance with a court order designating the maximum level of inpatient facility, if any, that may be used for treatment, subject to s. 51.06 (3).

3. The county department under s. 51.42 or 51.437 shall report to the court as to the initial plan of treatment for the subject individual.

(cm) *Omitted for this paper.*

(cr) *Omitted for this paper.*

(ct) *Omitted for this paper.*

(cv) *Omitted for this paper.*

(d) *Omitted for this paper.*

(dm) If the court finds that the dangerousness of the subject individual is likely to be controlled with appropriate medication administered on an outpatient basis, the court may direct in its order of commitment that the county department under s. 51.42 or 51.437 or the department may, after a facility evaluates the subject individual and develops an appropriate treatment plan, release the individual on a conditional transfer in accordance with s. 51.35 (1), with one of the conditions being that the individual shall take medication as prescribed by a physician, subject to the individual's right to refuse medication under s. 51.61 (1) (g) and (h), and that the individual shall report to a particular treatment facility on an outpatient basis for evaluation as often as required by the director of the facility or the director's designee. A finding by the court that the allegations under sub. (1) (a) 2. e. are proven constitutes a finding that the individual is not competent to refuse medication or treatment. The court order may direct that, if the director or his or her designee determines that the individual has failed to take the medication as prescribed or has failed to report for evaluation as directed, the director or designee may request that the individual be taken into custody by a law enforcement agency in accordance with s. 51.39, and that medication, as prescribed by the physician, may be administered voluntarily or against the will of the individual under s. 51.61 (1) (g) and (h). A court order under this paragraph is effective only as long as the commitment is in effect in accordance with par. (h) and s. 51.35 (4).

(e) The petitioner has the burden of proving all required facts by clear and convincing evidence.

(f) The county department under s. 51.42 or 51.437 that receives an individual who is committed by a court under par. (a) 3. is authorized to place the individual in an approved treatment facility, subject to any limitations which are specified by the court under par. (c) 2. The county department shall place the subject individual in the treatment program and treatment facility that is least restrictive of the individual's personal liberty, consistent with the treatment requirements of the individual. The county department has ongoing responsibility to review the individual's needs, in accordance with sub. (17), and to transfer the person to the least restrictive program consistent with the individual's needs. Placement or transfer under this paragraph is subject to s. 51.06 (3).

(g) 1. Except as provided in subd. 2., the first order of commitment of a subject individual under this section may be for a period not to exceed 6 months, and all subsequent consecutive orders of commitment of the individual may be for a period not to exceed one year.

2. *Omitted for this paper.*

2d. *Omitted for this paper.*

2g. *Omitted for this paper.*

2m. *Omitted for this paper.*

2r. *Omitted for this paper.*

3. *Omitted for this paper.*

(h) *Omitted for this paper.*

51.42 Community mental health, developmental disabilities, alcoholism and drug abuse services. (1) PROGRAM.

(a) *Purpose and intent.* All of the following are the purposes and intent of this section:

1. To enable and encourage counties to develop a comprehensive range of services offering continuity of care.
2. To utilize and expand existing governmental, voluntary and private community resources for provision of services to prevent or ameliorate mental disabilities, including but not limited to mental illness, developmental disabilities, alcoholism and drug abuse.
3. To provide for the integration of administration of those services and facilities organized under this section through the establishment of a county department of community programs.
4. To authorize state consultative services, reviews and establishment of standards and grants-in-aid for such program of services and facilities.

(b) County liability. The county board of supervisors has the primary responsibility for the well-being, treatment and care of the mentally ill, developmentally disabled, alcoholic and other drug dependent citizens residing within its county and for ensuring that those individuals in need of such emergency services found within its county receive immediate emergency services. This primary responsibility is limited to the programs, services and resources that the county board of supervisors is reasonably able to provide within the limits of available state and federal funds and of county funds required to be appropriated to match state funds. County liability for care and services purchased through or provided by a county department of community programs established under this section shall be based upon the client's county of residence except for emergency services for which liability shall be placed with the county in which the individual is found. For the purpose of establishing county liability, "emergency services" includes those services provided under the authority of s. 55.05 (4), 2003 stats., or s. 55.06 (11) (a), 2003 stats., or s. 51.15, 51.45 (11) (a) or (b) or (12), 55.13, or 55.135 for not more than 72 hours. Nothing in this paragraph prevents recovery of liability under s. 46.10 or any other statute creating liability upon the individual receiving a service or any other designated responsible party, or prevents reimbursement by the department of health and family services for the actual cost of all care and services from the appropriation under s. 20.435 (7) (da), as provided in s. 51.22 (3).

(2) DEFINITION. In this section, "program" means community services and facilities for the prevention or amelioration of mental disabilities, including but not limited to mental illness, developmental disabilities, alcoholism and drug abuse.

(3) COUNTY DEPARTMENT OF COMMUNITY PROGRAMS. (a) *Creation.* Except as provided under s. 46.23 (3) (b), the county board of supervisors of any county, or the county boards of supervisors of 2 or more contiguous counties, shall establish a county department of community programs on a single-county or multicounty basis to administer a community mental health, developmental disabilities, alcoholism and drug abuse program, make appropriations to operate the program and authorize the county department of community programs to apply for grants-in-aid under s. 51.423. The county department of community programs shall consist of a county community programs board, a county community programs director and necessary personnel.

(ar) *Duties.* A county department of community programs shall do all of the following:

1. *Omitted for this paper.*
2. *Omitted for this paper.*
3. *Omitted for this paper.*
4. Within the limits of available state and federal funds and of county funds required to be appropriated to match state funds, provide for the program needs of persons suffering from mental disabilities, including mental illness, developmental disabilities, alcoholism or drug abuse, by offering the following services:
 - a. Collaborative and cooperative services with public health and other groups for programs of prevention.
 - b. Comprehensive diagnostic and evaluation services, including assessment as specified under ss. 343.30 (1q) and 343.305 (10) and assessments under ss. 48.295 (1) and 938.295 (1).
 - c. Inpatient and outpatient care and treatment, residential facilities, partial hospitalization, emergency care and supportive transitional services.
 - d. Related research and staff in-service training, including periodic training on emergency detention procedures under s. 51.15, emergency protective services under s. 55.13, and emergency protective placement procedures under s. 55.135, for persons within the jurisdiction of the county department of community programs who are authorized to take individuals into custody under ss. 51.15 and 55.135. In developing in-service training on emergency detention and emergency protective placement procedures, the county department of community programs shall consult the county department of developmental disabilities services under s. 51.437 in counties where these departments are separate.
 - e. Continuous planning, development and evaluation of programs and services for all population groups.

4m. If state, federal and county funding for alcohol and other drug abuse treatment services provided under subd. 4. are insufficient to meet the needs of all eligible individuals, ensure that first priority for services is given to pregnant women who suffer from alcoholism or alcohol abuse or are drug dependent.

5. Prepare a local plan which includes an inventory of all existing resources, identifies needed new resources and services and contains a plan for meeting the needs of the mentally ill, developmentally disabled, alcoholic, drug abusers and those with other psychiatric disabilities for citizens residing within the jurisdiction of the county department of community programs and for persons in need of emergency services found within the jurisdiction of the county department of community programs. The plan shall also include the establishment of long-range goals and intermediate-range plans, detailing priorities and estimated costs and providing for coordination of local services and continuity of care. The plan shall state how the needs of homeless persons and adults with serious and persistent mental illness, children with serious emotional disturbances and minorities will be met by the county department of community programs. The county department of community programs shall submit the plan to the department for review under sub. (7) (a) 9. and s. 51.02 (1) (f) in accordance with the schedule and deadlines established under sub. (7) (a) 9.

6. *Omitted for this paper.*

7. *Omitted for this paper.*

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18. *Omitted for this paper.*

(as) *Omitted for this paper.*

51.61(1)(e) Except in the case of a patient who is admitted or transferred under s. 51.35 (3) or 51.37 or under ch. 971 or 975, have the right to the least restrictive conditions necessary to achieve the purposes of admission, commitment or protective placement, under programs, services and resources that the county board of supervisors is reasonably able to provide within the limits of available state and federal funds and of county funds required to be appropriated to match state funds.

Pertinent State Statutes – Chapter 54, Guardianships and Conservatorships

54.01 (6) “Degenerative brain disorder” means the loss or dysfunction of an individual’s brain cells to the extent that he or she is substantially impaired in his or her ability to provide adequately for his or her own care or custody or to manage adequately his or her property or financial affairs.

(14) “Impairment” means a developmental disability, serious and persistent mental illness, degenerative brain disorder, or other like incapacities.

(15) “Incapacity” means the inability of an individual effectively to receive and evaluate information or to make or communicate a decision with respect to the exercise of a right or power.

(16) “Individual found incompetent” means an individual who has been adjudicated by a court as meeting the requirements of s. 54.10 (3).

(22) “Other like incapacities” means those conditions incurred at any age that are the result of accident, organic brain damage, mental or physical disability, or continued consumption or absorption of substances, and that produce a condition that substantially impairs an individual from providing for his or her own care or custody.

54.10 Appointment of guardian. (1) A court may appoint a guardian of the person or a guardian of the estate, or both, for an individual if the court determines that the individual is a minor.

(2) (a) A court may appoint a guardian of the estate for an individual if the court finds by clear and convincing evidence that the individual is aged at least 18 years and is a spendthrift.

(b) In appointing a guardian of the estate under this subsection or determining what powers are appropriate for the guardian of the estate to exercise under s. 54.18 or 54.20, the court shall consider all of the following:

1. The report of the guardian ad litem, as required in s. 54.40 (4).

2. The medical or psychological report provided under s. 54.36 (1) and any additional medical, psychological, or other evaluation ordered by the court under s. 54.40 (4) (e) or offered by a party and received by the court.

3. Whether other reliable resources are available to provide for the individual's personal needs or property management, and whether appointment of a guardian of the estate is the least restrictive means to provide for the individual's need for a substitute decision maker.

4. The preferences, desires, and values of the individual with regard to personal needs or property management.

5. The nature and extent of the individual's care and treatment needs and property and financial affairs.

6. Whether the individual's situation places him or her at risk of abuse, exploitation, neglect, or violation of rights.

7. The extent of the demands placed on the individual by his or her personal needs and by the nature and extent of his or her property and financial affairs.

8. Any mental disability, alcoholism, or other drug dependence of the individual and the prognosis of the mental disability, alcoholism, or other drug dependence.

9. Whether the effect on the individual's evaluative capacity is likely to be temporary or long term, and whether the effect may be ameliorated by appropriate treatment.

10. Other relevant evidence.

(c) Before appointing a guardian of the estate under this subsection or determining what powers are appropriate for the guardian of the estate to exercise under s. 54.18 or 54.20, the court shall determine if additional medical, psychological, social, vocational, or educational evaluation is necessary for the court to make an informed decision respecting the individual.

(d) In appointing a guardian of the estate under this subsection, the court shall authorize the guardian of the estate to exercise only those powers under ss. 54.18 and 54.20 that are necessary to provide for the individual's personal needs and property management and to exercise the powers in a manner that is appropriate to the individual and that constitutes the least restrictive form of intervention.

(3) (a) A court may appoint a guardian of the person or a guardian of the estate, or both, for an individual based on a finding that the individual is incompetent only if the court finds by clear and convincing evidence that all of the following are true:

1. The individual is aged at least 17 years and 9 months.

2. For purposes of appointment of a guardian of the person, because of an impairment, the individual is unable effectively to receive and evaluate information or to make or communicate decisions to such an extent that the individual is unable to meet the essential requirements for his or her physical health and safety.

3. For purposes of appointment of a guardian of the estate, because of an impairment, the individual is unable effectively to receive and evaluate information or to make or communicate decisions related to management of his or her property or financial affairs, to the extent that any of the following applies:

a. The individual has property that will be dissipated in whole or in part.

b. The individual is unable to provide for his or her support.

c. The individual is unable to prevent financial exploitation.

4. The individual's need for assistance in decision making or communication is unable to be met effectively and less restrictively through appropriate and reasonably available training, education, support services, health care, assistive devices, or other means that the individual will accept.

(b) Unless the proposed ward is unable to communicate decisions effectively in any way, the determination under par. (a) may not be based on mere old age, eccentricity, poor judgment, or physical disability.

(c) In appointing a guardian under this subsection, declaring incompetence to exercise a right under s. 54.25 (2) (c), or determining what powers are appropriate for the guardian to exercise under s. 54.18, 54.20, or 54.25 (2) (d), the court shall consider all of the following:

1. The report of the guardian ad litem, as required in s. 54.40 (4).

2. The medical or psychological report provided under s. 54.36 (1) and any additional medical, psychological, or other evaluation ordered by the court under s. 54.40 (4) (e) or offered by a party and received by the court.

3. Whether the proposed ward has engaged in any advance planning for financial and health care decision making that would avoid guardianship, including by executing a durable power of attorney under ch. 243, a power of attorney for health care, as defined in s. 155.01 (10), a trust, or a jointly held account.

4. Whether other reliable resources are available to provide for the individual's personal needs or property management, and whether appointment of a guardian is the least restrictive means to provide for the individual's need for a substitute decision maker.

5. The preferences, desires, and values of the individual with regard to personal needs or property management.

6. The nature and extent of the individual's care and treatment needs and property and financial affairs.

7. Whether the individual's situation places him or her at risk of abuse, exploitation, neglect, or violation of rights.

8. Whether the individual can adequately understand and appreciate the nature and consequences of his or her impairment.

9. The individual's management of the activities of daily living.

10. The individual's understanding and appreciation of the nature and consequences of any inability he or she may have with regard to personal needs or property management.

11. The extent of the demands placed on the individual by his or her personal needs and by the nature and extent of his or her property and financial affairs.

12. Any physical illness of the individual and the prognosis of the individual.

13. Any mental disability, alcoholism, or other drug dependence of the individual and the prognosis of the mental disability, alcoholism, or other drug dependence.

14. Any medication with which the individual is being treated and the medication's effect on the individual's behavior, cognition, and judgment.

15. Whether the effect on the individual's evaluative capacity is likely to be temporary or long term, and whether the effect may be ameliorated by appropriate treatment.

16. Other relevant evidence.

(d) Before appointing a guardian under this subsection, declaring incompetence to exercise a right under s. 54.25 (2) (c), or determining what powers are appropriate for the guardian to exercise under s. 54.18, 54.20, or 54.25 (2) (d), the court shall determine if additional medical, psychological, social, vocational, or educational evaluation is necessary for the court to make an informed decision respecting the individual's competency to exercise legal rights and may obtain assistance in the manner provided in s. 55.06 (8) [s. 55.11 (1)] whether or not protective placement is made.

NOTE: The correct cross-reference is shown in brackets. Corrective legislation is pending.

(e) In appointing a guardian under this subsection, the court shall authorize the guardian to exercise only those powers under ss. 54.18, 54.20, and 54.25 (2) (d) that are necessary to provide for the individual's personal needs and property management and to exercise the powers in a manner that is appropriate to the individual and that constitutes the least restrictive form of intervention.

(4) If the court appoints both a guardian of the person and a guardian of the estate for an individual other than an individual found to be a spendthrift, the court may appoint separate persons to be guardian of the person and of the estate, or may appoint one person to act as both.

(5) The court may appoint coguardians of the person or coguardians of the estate, subject to any conditions that the court imposes.

Pertinent State Statutes – Chapter 55, Protective Services System

55.15 Transfer of an individual under a protective placement order. (1) TRANSFERS AUTHORIZED.
An individual under a protective placement order may be transferred between protective placement units, between protective placement facilities, or from a protective placement unit to a medical facility. The individual may not be transferred, under the protective placement order, to any facility for which commitment procedures are required under ch. 51.

(2) WHO MAY TRANSFER. A guardian, a county department or agency with which it contracts under s. 55.03 (2) [s. 55.02 (2)] that provided protective placement to the individual pursuant to the order of the court, the department, or a protective placement facility may transfer an individual under a protective placement order under the requirements of this section, notwithstanding the fact that a court order has named a specific facility for the protective placement of the individual.

NOTE: The bracketed language indicates the correct cross-reference. Corrective legislation is pending.

(3) CONSENT OF GUARDIAN REQUIRED. No individual may be transferred under this section without the written consent of the individual's guardian, except in the case of an emergency transfer under sub. (5) (b).

(4) CONSENT OF COUNTY DEPARTMENT. No individual may be transferred under this section to a facility that is more costly to the county without the written consent of the county department, except in the case of an emergency transfer under sub. (5) (b).

(5) NOTICE OF TRANSFER. (a) *Nonemergency transfer.* A person or entity who initiates a transfer shall provide 10 days' prior written notice of a transfer to the court that ordered the protective placement and to each of the other persons and entities specified in sub. (2) who did not initiate the transfer. The notice of transfer shall include notice of the right of the individual under a protective placement, the individual's attorney, if any, or other interested person to petition the court for a hearing on the transfer.

(b) *Emergency transfer.* If an emergency makes it impossible to provide the notice specified in par. (a) or to obtain the prior written consent of the guardian specified in sub. (3), the individual may be transferred without the prior written consent of the guardian and without the notice specified in par. (a). Written notice shall be provided immediately upon transfer to each of the persons and entities specified under sub. (2) who did not initiate the transfer. Notice shall also be provided to the court that ordered the protective placement within a reasonable time, not to exceed 48 hours from the time of transfer. The notice shall include notice of the right to file with the court under sub. (6) a petition objecting to the emergency transfer.

(6) PETITION. An individual under protective placement, the individual's guardian, the individual's attorney, if any, or any other interested person may file a petition with the court objecting to a proposed transfer or to an emergency transfer made under sub. (5) (b). The petition shall specify the reasons for the person's objection to the transfer.

(7) HEARING. (a) The court shall order a hearing within 10 days after the filing of a petition under sub. (6).

(b) The court shall notify the petitioner, the individual under protective placement, the individual's guardian, the individual's attorney, if any, and the county department of the time and place of the hearing.

(c) A guardian ad litem shall be appointed to represent the individual under protective placement at the hearing. If the individual is an adult who is indigent, the county in which the hearing is held shall be liable for guardian ad litem fees. If the individual is a minor, the individual's parents or the county in which the hearing is held shall be liable for guardian ad litem fees as provided in s. 48.235 (8).

(cm) The court shall appoint counsel for the individual under protective placement if the individual, the individual's guardian ad litem, or anyone on the individual's behalf requests that counsel be appointed for the individual.

(d) The petitioner, individual under protective placement, the individual's guardian, the individual's guardian ad litem, and the individual's attorney, if any, have the right to attend the hearing and to present and cross-examine witnesses.

(8) STANDARD FOR TRANSFER. In determining whether to approve a proposed transfer or an emergency transfer made under sub. (5) (b), the court shall consider all of the following:

(a) Whether the requirements of s. 55.12 (2) and (6) are met.

(b) Whether the protective placement is in the least restrictive environment consistent with the requirements of s. 55.12 (3), (4), and (5) or, if the transfer is to an intermediate facility or nursing facility, is in the most integrated setting, as defined in s. 46.279 (1) (bm).

(c) Whether the protective placement is in the best interests of the person under protective placement.

(9) ORDER RELATING TO TRANSFER. Following the hearing under sub. (7), the court shall do one of the following:

(a) If the court finds that the individual continues to meet the standards under s. 55.08 (1) and the individual's proposed protective placement does not meet the standards for transfer under sub. (8), the court shall issue an order prohibiting the transfer. The court shall include the information relied upon as a basis for the order and shall make findings based on the standards under sub. (8) in support of the denial of the transfer.

(b) If the court finds that the individual continues to meet the standards under s. 55.08 (1) and the proposed transfer meets the standard under sub. (8), the court shall approve the proposed transfer. The court may order protective services along with transfer of protective placement. The court shall include the information relied upon as a basis for the order and shall make findings based on the standards in s. 55.08 (1) in support of the need for continued protective placement.

(c) If the court finds that the individual no longer meets the standards under s. 55.08 (1), the court shall terminate the protective placement, as provided in s. 55.17.

Pertinent Federal Regulations – Hospitals

§ 482.43 Condition of participation: Discharge planning. The hospital must have in effect a discharge planning process that applies to all patients. The hospital's policies and procedures must be specified in writing.

(a) Standard: Identification of patients in need of discharge planning. The hospital must identify at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning.

(b) Standard: Discharge planning evaluation.

(1) The hospital must provide a discharge planning evaluation to the patients identified in paragraph (a) of this section, and to other patients upon the patient's request, the request of a person acting on the patient's behalf, or the request of the physician.

(2) A registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise the development of, the evaluation.

(3) The discharge planning evaluation must include an evaluation of the likelihood of a patient needing post-hospital services and of the availability of the services.

(4) The discharge planning evaluation must include an evaluation of the likelihood of a patient's capacity for selfcare or of the possibility of the patient being cared for in the environment from which he or she entered the hospital.

(5) The hospital personnel must complete the evaluation on a timely basis so that appropriate arrangements for post-hospital care are made before discharge, and to avoid unnecessary delays in discharge.

(6) The hospital must include the discharge planning evaluation in the patient's medical record for use in establishing an appropriate discharge plan and must discuss the results of the evaluation with the patient or individual acting on his or her behalf.

(c) Standard: Discharge plan. (1) A registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise the development of, a discharge plan if the discharge planning evaluation indicates a need for a discharge plan.

(2) In the absence of a finding by the hospital that a patient needs a discharge plan, the patient's physician may request a discharge plan. In such a case, the hospital must develop a discharge plan for the patient.

(3) The hospital must arrange for the initial implementation of the patient's discharge plan.

(4) The hospital must reassess the patient's discharge plan if there are factors that may affect continuing care needs or the appropriateness of the discharge plan.

(5) As needed, the patient and family members or interested persons must be counseled to prepare them for post-hospital care.

(6) The hospital must include in the discharge plan a list of HHAs or SNFs that are available to the patient, that are participating in the Medicare program, and that serve the geographic area (as defined by the HHA) in which the patient resides, or in the case of a SNF, in the geographic area requested by the patient. HHAs must request to be listed by the hospital as available.

(i) This list must only be presented to patients for whom home health care or post-hospital extended care services are indicated and appropriate as determined by the discharge planning evaluation.

(ii) For patients enrolled in managed care organizations, the hospital must indicate the availability of home health and posthospital extended care services through individuals and entities that have a contract with the managed care organizations.

(iii) The hospital must document in the patient's medical record that the list was presented to the patient or to the individual acting on the patient's behalf.

(7) The hospital, as part of the discharge planning process, must inform the patient or the patient's family of their freedom to choose among participating Medicare providers of posthospital care services and must, when possible, respect patient and family preferences when they are expressed. The hospital must not specify or otherwise limit the qualified providers that are available to the patient.

(8) The discharge plan must identify any HHA or SNF to which the patient is referred in which the hospital has a disclosable financial interest, as specified by the Secretary, and any HHA or SNF that has a disclosable financial interest in a hospital under Medicare. Financial interests that are disclosable under Medicare are determined in accordance with the provisions of Part 420, Subpart C, of this chapter.

(d) Standard: Transfer or referral. The hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for followup or ancillary care.

(e) Standard: Reassessment. The hospital must reassess its discharge planning process on an on-going basis. The reassessment must include a review of discharge plans to ensure that they are responsive to discharge needs.

Pertinent Federal Regulations – Medicaid-certified Nursing Facilities

§ 483.12 Admission, transfer and discharge rights.

(a) Transfer and discharge—

(1) *Definition:* Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.

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

(i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;

(ii) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

(iii) The safety of individuals in the facility is endangered;

(iv) The health of individuals in the facility would otherwise be endangered;

(v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or

(vi) The facility ceases to operate.

(3) *Documentation.* When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by—

(i) The resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and (ii) A physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.

(4) Notice before transfer. Before a facility transfers or discharges a resident, the facility must—

(i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.

(ii) Record the reasons in the resident's clinical record; and

(iii) Include in the notice the items described in paragraph (a)(6) of this section.

(5) Timing of the notice. (i) Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.

(ii) Notice may be made as soon as practicable before transfer or discharge when—

(A) the safety of individuals in the facility would be endangered under paragraph (a)(2)(iii) of this section;

(B) The health of individuals in the facility would be endangered, under paragraph (a)(2)(iv) of this section;

(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(ii) of this section;

(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(i) of this section; or

(E) A resident has not resided in the facility for 30 days.

(6) *Contents of the notice.* The written notice specified in paragraph (a)(4) of this section must include the following:

(i) The reason for transfer or discharge;

(ii) The effective date of transfer or discharge;

(iii) The location to which the resident is transferred or discharged;

(iv) A statement that the resident has the right to appeal the action to the State;

(v) The name, address and telephone number of the State long term care ombudsman;

(vi) For nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and

(vii) For nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.

(7) Orientation for transfer or discharge. A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

(8) *Room changes in a composite distinct part.* Room changes in a facility that is a composite distinct part (as defined in § 483.5(c)) must be limited to moves within the particular building in which the resident resides, unless the resident voluntarily agrees to move to another of the composite distinct part's locations.

(b) *Notice of bed-hold policy and readmission*—(1) *Notice before transfer.* Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies—

(i) The duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility; and

(ii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return.

(2) *Bed-hold notice upon transfer.* At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.

(3) *Permitting resident to return to facility.* A nursing facility must establish and follow a written policy under which a resident, whose hospitalization or therapeutic leave exceeds the bedhold period under the State plan, is readmitted to the facility immediately upon the first availability of a bed in a semi-private room if the resident—

(i) Requires the services provided by the facility; and

(ii) Is eligible for Medicaid nursing facility services.

(4) *Readmission to a composite distinct part.* When the nursing facility to which a resident is readmitted is a composite distinct part (as defined in § 483.5(c) of this subpart), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of readmission, the resident must be given the option to return to that location upon the first availability of a bed there.

(c) *Equal access to quality care.* (1) A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all individuals regardless of source of payment;

(2) The facility may charge any amount for services furnished to non-Medicaid residents consistent with the notice requirement in § 483.10(b)(5)(i) and (b)(6) describing the charges; and

(3) The State is not required to offer additional services on behalf of a resident other than services provided in the State plan.

(d) *Admissions policy.* (1) The facility must—

(i) Not require residents or potential residents to waive their rights to Medicare or Medicaid; and

(ii) Not require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits.

(2) The facility must not require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may require an individual who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources.

(3) In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility. However,—

(i) A nursing facility may charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the State plan as included in the term "nursing facility services" so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident's admission or continued stay on the request for and receipt of such additional services; and

(ii) A nursing facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility for a Medicaid eligible resident.

(4) States or political subdivisions may apply stricter admissions standards under State or local laws than are specified in this section, to prohibit discrimination against individuals entitled to Medicaid.

§ 483.20 Resident assessment. The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity.

(a) *Admission orders.* At the time each resident is admitted, the facility must have physician orders for the resident's immediate care.

(b) Comprehensive assessments—(1) Resident assessment instrument. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:

(i) Identification and demographic information.

(ii) Customary routine.

(iii) Cognitive patterns.

(iv) Communication.

(v) Vision.

(vi) Mood and behavior patterns.

(vii) Psychosocial well-being.

(viii) Physical functioning and structural problems.

(ix) Continence.

(x) Disease diagnoses and health conditions.

(xi) Dental and nutritional status.

(xii) Skin condition.

(xiii) Activity pursuit.

(xiv) Medications.

(xv) Special treatments and procedures.

(xvi) Discharge potential.

(xvii) Documentation of summary information regarding the additional assessment performed through the resident assessment protocols.

(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

(2) *When required.* Subject to the timeframes prescribed in § 413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2) (i) through (iii) of this section. The timeframes prescribed in § 413.343(b) of this chapter do not apply to CAHs.

(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.)

(ii) Within 14 calendar days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purposes of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)

(iii) Not less often than once every 12 months.

(c) *Quarterly review assessment.* A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.

(d) *Use.* A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review, and revise the resident's comprehensive plan of care.

(e) *Coordination.* A facility must coordinate assessments with the preadmission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort.

(f) *Omitted for this paper.*

(g) *Omitted for this paper.*

(h) *Omitted for this paper.*

(i) *Omitted for this paper.*

(j) *Omitted for this paper.*

(k) Comprehensive care plans. (1) The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following—

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under § 483.25; and

(ii) Any services that would otherwise be required under § 483.25 but are not provided due to the resident's exercise of rights under § 483.10, including the right to refuse treatment under § 483.10(b)(4).

(2) A comprehensive care plan must be—

(i) Developed within 7 days after completion of the comprehensive assessment;

(ii) Prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and

(iii) Periodically reviewed and revised by a team of qualified persons after each assessment.

(3) The services provided or arranged by the facility must—

(i) Meet professional standards of quality; and

(ii) Be provided by qualified persons in accordance with each resident's written plan of care.

(l) *Omitted for this paper.*

(m) *Omitted for this paper.*

§ 483.25 Quality of care. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

(a) Activities of daily living. Based on the comprehensive assessment of a resident, the facility must ensure that—

(1) A resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to—

(i) Bathe, dress, and groom;

(ii) Transfer and ambulate;

(iii) Toilet;

(iv) Eat; and

(v) Use speech, language, or other functional communication systems.

(2) A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section; and

(3) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

(b) *Omitted for this paper.*

(c) *Omitted for this paper.*

(d) *Omitted for this paper.*

(e) *Omitted for this paper.*

(f) Mental and Psychosocial functioning. Based on the comprehensive assessment of a resident, the facility must ensure that—

(1) A resident who displays mental or psychosocial adjustment difficulty, receives appropriate treatment and services to correct the assessed problem, and

(2) A resident whose assessment did not reveal a mental or psychosocial adjustment difficulty does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that such a pattern was unavoidable.

(g) *Omitted for this paper.*

(h) *Omitted for this paper.*

(i) *Omitted for this paper.*

(j) *Omitted for this paper.*

(k) *Omitted for this paper.*

(1) Unnecessary drugs—(1) General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:

(i) In excessive dose (including duplicate drug therapy); or

(ii) For excessive duration; or

(iii) Without adequate monitoring; or

(iv) Without adequate indications for its use; or

(v) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or

(vi) Any combinations of the reasons above.

(2) Antipsychotic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that—

(i) Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and

(ii) Residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

§ 483.30 Nursing services. The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

(a) *Sufficient staff.* (1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

(i) Except when waived under paragraph (c) of this section, licensed nurses; and

(ii) Other nursing personnel.

(2) Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

§ 483.45 Specialized rehabilitative services.

(a) *Provision of services.* If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must—

(1) Provide the required services; or

(2) Obtain the required services from an outside resource (in accordance with § 483.75(h) of this part) from a provider of specialized rehabilitative services.

(b) *Qualifications.* Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel.

Nursing Home Response

Question a) What type of issues or problems might I encounter?

*I would question if any work up had been completed to rule out underlying delirium; pain; infection; etc. Is she comfort care/palliative care? Is she having pain but cannot verbalize it?

*Some of the issues with geriatric/dementia populations on psych units I've encountered include:

The psych units want a quick fix, or they do a band-aid approach rather than addressing the underlying problem.

Typically, a geriatric demented patient is rather quickly medicated to the point of sedation. Often times, ambulation diminishes rapidly and there is a decline with eating, ADL's, etc.

The hospital psych staff (i.e. Psychiatrists; RN's, SW's) lack in training to manage the symptoms of dementia/delirium; this is evident when we have assessed these individuals on numerous occasions.

It is common knowledge that acute psych populations and dementia patients don't do well together.

The staff/resident ratio on a psych unit will be much higher than that of any long-term care facility. It is not uncommon for demented individuals to be isolated from other patients so it is hard to get a real picture of how this person will respond to others in a larger NH setting.

Because of the costs in an acute setting and low reimbursement rates coupled with the inappropriate placement of dementia on psych units the goal seems to be to get them in and out as quickly as possible.

The use of IM medication is frequently used which, even with a court ordered medication, is not a desirable fix for a frail, demented elderly person.

*The medical units at hospitals are also not an ideal place; they admit people to fix medical problems and do not want to deal with behavioral symptoms. Dementia patients are highly susceptible to delirium with any change in their environment, health, medications, etc. Increase in confusion/falls/wandering/resistance to treatment/cares, etc., are great. The medical units want to stabilize medically and discharge ASAP.

*There is unwillingness for NH's to admit because of the lack of staffing to provide a "one to one" with an agitated person. Those folks with dementia and challenging behavioral symptoms are labor intense to manage. This person would be at risk of causing injury to others or to themselves (i.e. falls, peer to peer aggression, elopements, etc.). Plus, the person in the scenario would likely be with many other demented residents. HSS 132 Codes are not forgiving when something "bad" happens. There is a zero tolerance for peer-to-peer aggression. Falls and psychotropic medication reductions are always looked at closely. Medications are always a trial and error; often times making behavior symptoms worse rather than better. The side effects of the meds themselves may cause problems with gait.... this can lead to a decrease in mobility which in turn places the individual at risk for falls and pressure ulcers.... an increase in lethargy can cause a decrease with their intake and weight loss.... and the list goes on.

*There is no way of predicting what course the individual will take once admitted to the NH. Once placed, it is the responsibility of the facility to keep them safe and at their optimal functioning level. To complicate an already difficult situation, the state survey process will cite facilities for things mentioned above (i.e. falls, peer to peer aggression, chemical restraints, pressure ulcers, etc.).

*Bottom line... there is a lack of resources and expertise to address the growing concerns of the dementia person who demonstrate challenging behaviors. There is no magic pill or quick fix to address such complex problems. It is a great injustice for both the individual suffering from dementia and for their families.

Q b) What type of responses are you aware of that would assist in a case like this?

*I would try to advocate that the hospital rule out pain as an underlying cause of the behavior symptom. Ask them to taper/hold the medications...to go slower, not just manage behaviors by over medicating quickly.

*Advocate for a gerontologist consult or a psychiatrist who has some expertise in the field of dementia.

*If they have truly tried to manage the symptoms the best that they can and the symptoms are less intense, put pressure on the NH that discharged. Call and get input from the State Ombudsman.

*Obtain some form of agreement with DHHS that has a back up plan if the person goes back to a NH... that if necessary a transfer out can be made. Included may be an outline of the criteria; what behavior symptoms warrant a transfer; where would the person be transferred to; alert the county Crisis Team; etc.

*Start having conversations with the family/decision maker about end of life decisions. If the person is palliative care and none of the approaches and medications typically used are effective; do we error on the side of pain medications as management. Perhaps there are underlying physical discomforts and obviously in this case, there is mental anguish as well. Weigh the benefits vs. the risks; what would the person want if they were able to communicate with us? Document well decisions made by the one who has the authority to make these types of decisions. If comfort care is chosen, offer to get hospice on board. As always, families need much support during these difficult times.

Yvonne Rochon
Social Worker @ Brewster Village

Law Enforcement Perspective from Todd Freeman, CIT/APD

As for the scenario, the police portion involves initial assessment of the person for detention. These are very difficult calls and we have worked extensively on trying to educate our local nursing homes / assisted living facilities on the requirements we need to meet for an emergency detention as well as options outside of police involvement (three party petition, etc.). The scenario here includes the necessary "dangerousness" element that is often missing from many such cases. It would seem that a detention is in order if placement with family is not an option - as it usually is not when there are medical care needs as well.

As for the Chapter 51 vs. 55, that is really not an issue the police get involved with. We perform the initial detention - usually always under Ch. 51 and Human Services and the Corp. Counsel's office modify it to a Ch. 55 if they feel it fits better. From our perspective, ceasing the dangerous behavior and the welfare of the individual is the goal.

It looks like in this scenario, the family may be more involved than others. I would expect our officers to involve the family members in the solution (particularly when there are not severe medical issues) and avoid a detention if at all possible. Too often, an elderly person's disruptive behavior and general discontent gets lumped under the "dangerous" umbrella and police are called. Likewise, some residents just become too high maintenance to care for some facilities. An emergency detention should not be used because the person is difficult or as a last resort to get a person removed from a facility. The statute is pretty clear and applies to everyone, young and old.

I hope this helps.

Todd Freeman
APD

Ombudsman Response to Case Scenario for Aging Crisis Forum

All too often we, as Ombudsmen, receive calls just like this case scenario. And often times our response is the same. We usually tell facilities, per regulations and resident rights, residents have the right to remain in the facility unless there is a valid, legal reason for their transfer or discharge. Nursing homes have an obligation to their residents. They must reassess the resident and their current status and take the resident back!

As Ombudsmen, we do not minimize the fact that these situations are difficult. In fact, these are probably the most difficult situations that a facility must face. However, as advocates, providers, county agencies and hospitals, we must remember that we are dealing with a very vulnerable population that deserves our utmost care and respect. I would like to share with you today, ways in which, the Ombudsman Program can help when a situation, like this case scenario, comes up at your facility. One way we can help is to...

- Provide consultation to Nursing Home/CBRF before the crisis happens...the best way to avoid this scenario from happening at your facility is...prevention
 - Prevention –
 - Ongoing Assessment – 24/7; a good facility assesses continually --- KNOW YOUR RESIDENT
 - Behavior Flow sheets – 5 W’s (who, what, where, when, why) over a time period; what was happening when behaviors occurred.
 - Medical conditions affecting behaviors – a vast majority of challenging behaviors are medically induced, UTI, pain, etc
 - Environmental issues (noise, room setup, roommate)
 - 1:1 or other activities (dementia related activities)
 - Consistent/Adequate/Well-trained Staff – having staff that are consistently providing care to the same individuals builds trusting relationships
 - Offer family support – talk with family about feelings, behaviors, expectations, concerns, etc.
 - Were there behaviors before she entered the NH?
 - Calling police may have brought back even more memories?
 - Being on locked unit may exacerbate the behaviors – brainstorming with the facility about alternatives
 - Person-Directed Care (I care plan, familiar routine as home, what did she used to do, hobbies, etc)
 - Keep old approaches in place...don’t be afraid to go back to something that didn’t work in the past. It might work this time or for another resident.
 - Training for staff – training is never wasted, if you don’t use what you learned now, you will use it some day. For example: Training staff on ways to appropriately approach a resident who has challenging behaviors. It is not fair to put staff who are ill-prepared in challenging situations.
 - Resources

- Family/Resident – again know your resident!
 - Staff – ask for solutions; ask staff on all shifts
 - Primary Physician/Medical Director
 - Pharmacist – med interactions or changes
- ** Notice the above 4 should all be right at your fingertips, they all are apart of your facility staff.
- Geriatric Psychiatrist
 - Behavioral Specialist/Psychologist
 - Alzheimer’s Association
 - Memory Assessment Clinics
 - Ombudsman
 - Division of Quality Assurance – either NH or CBRF
 - Culture Change...Advancing Excellence in America’s NH’s. If you are not apart of it, I encourage you to join. This is a national campaign that providers and consumers are a part of to improve the quality of care and life for NH residents. I put this as a resource b/c there are several goals to choose from that we have talked about as preventions/resources
 - Consistent Assignment, Family/Resident Satisfaction, medical conditions, pain, physical restraints

Another area the Ombudsman can be helpful with is...

- Provide education on Resident Rights (these are just some of the rights, this is not an all-inclusive list)
 - To be treated with courtesy, respect and dignity, free from humiliation, harassment or threats
 - To expect the facility to accommodate individual needs and preferences – Person-Directed Care
 - To participate in the planning of your care and services – resident and family/guardian should be involved in care planning; they may hold valuable information that could help the resident. Be informed of what the care plan is and the goals and timeframes are. Make sure family understands the care plan and all questions are answered.
 - To remain in the facility unless there is a valid, legal reason for your transfer or discharge.
 - To voice grievances about care or services without discrimination or reprisal.
 - To contact the Ombudsman to advocate on your behalf if you feel any of your rights have been violated.
 - Right to be free from physical and chemical restraints – This right does not prohibit you from using physical/chemical restraints. Rather, it requires

you to assess, monitor, care plan and look for the least restrictive measure to effectively treat the resident's symptoms. The resident has the right to be free from adverse reactions when using either physical or chemical restraints.

Even though a facility has looked at ways to prevent the behaviors, used resources available to them, and have been educated on resident rights, the resident may still need further treatment. So, how can the Ombudsman help after the resident has been transferred to a psych unit?

- Provide Consultation to all facilities...Psych Unit/NH/CBRF – this is really where teamwork comes into play. The NH/CBRF and psych unit must come together as a team and understand each other's role. This is not a time for the NH/CBRF staff to take a 3 day vacation from that resident. And on the flip side, this is not the time that the psych unit or hospital takes over and “snows” or restrains the resident in ways that the NH would not be able to. Both parties have a responsibility to the resident to make sure they receive the treatment they deserve. So what are some ways that the 2 parties can work together:
 - Make sure the resident receives treatment...if the psych unit admits for treatment, treat the behaviors...sedating and restraining is not a form of treatment...need to find interventions that provides a good quality of life for the resident. As I said earlier, both parties of an obligation to make sure the resident receives the treatment they deserve.
 - Articulate expectations...both sides need to let each other know what they can expect from their facility and the care they can provide. NH/CBRF should be letting the psych unit know what they want as an expected outcome. And vice versa, psych unit should inform the NH/CBRF what they think the outcome is going to be. (Remember to have reasonable expectations...do not expect zero behaviors, rather be realistic and look for a decrease in those behaviors.) Both sides need to understand each other's role and regulations in re: to the care they can provide.
 - Keep communication ongoing between NH/CBRF and psych unit...make personal contacts with facility staff, visit the resident at the hospital, call and give updates on a daily basis.
- Nursing home and CBRF regs re: transfer and discharge procedures – Psych Units need to understand how a NH or CBRF operate under regs. And vice versa.
 - Prepare for return of resident...again both sides need to be preparing for return of resident. NH/CBRF needs to be meeting with staff of psych unit, family, resident, doctors, ombudsman or other resources to talk about discharge plans and to put together a good care plan to provide a good quality of life for the resident when they return to the facility. On the other hand, the psych unit needs to start preparing a discharge plan with the NH/CBRF about what behavior interventions are going to be needed and

what the facility can expect when they are going to be re-admitting the resident. The other piece of information both sides are going to want to talk about is Transfer Trauma. The main focus of preparing for the return of the resident needs to be the resident! I brought along a hand out that summarizes what Transfer Trauma is, some of the signs associated with it and some methods on ways to avoid it.

- Provide education on Transfer Trauma Awareness – use handout
 - Moving from NH – psych unit – hospital – back to NH (perhaps different one) See this too many times!
 - Definition and description
 - Characteristics
 - Methods to Avoid Transfer Trauma

Transfer Trauma Awareness

Important Information for Residents, Their Families, and for Discharging and Admitting Homes

Transfer Trauma, also called Relocation Stress Syndrome, is defined as “physiologic and/or psychosocial disturbances as a result of transfer from one environment to another.”

It is described as “a wave of disorientation and despair so intense that it can kill.”

Transfer Trauma is very real and dangerous. It can result from any move from one environment to another, regardless of the reason for the move. This includes moves from home to nursing home, group home to hospital, one room to another room, nursing home to nursing home, nursing home to home, etc. If adequate measures are not taken to prepare the individual for any move, Transfer Trauma can occur.

Characteristics of Transfer Trauma:

- Depression
- Falls
- Confusion
- Anxiety
- Weight change
- Sadness
- Dependency
- Apprehension
- Loneliness
- Insecurity
- Restlessness
- Distrust
- Withdrawal/isolation
- Sleep disturbance
- Change in eating habits
- Stomach problems
- Crying
- Anger
- Aggressiveness
- Noncompliance
- Unwillingness to move
- Expressing concern
- Being upset
- Negative comments about staff
- Despair
- Hallucinations
- Indecision
- Death

For some people, the symptoms of transfer trauma may be obvious changes in health, personality or disposition. For others, the changes may be very subtle. It is critical that the receiving facility understand what a resident is *usually* like, so any changes, obvious or subtle, are recognized as transfer trauma

Methods to Avoid Transfer Trauma:

Conduct thorough planning, involve the individual in all aspects of the move, keep the resident informed, present an optimistic and favorable attitude, use humor and praise

- Present options, offer tours, honor preferences, allow the resident to maintain control
- Do not argue, do not give orders, do not take the resident's behavior personally
- Safeguard personal possessions, help pack and move possessions, involve the resident and family, set up new room similar to old room
- Pay attention to detail—ensure consistent approaches for medical care, especially assistance with eating and medication administration
- Think of everything—phone hook-ups, new mailing address, maintaining relationships, etc.
- Be prepared, be organized—avoid chaos, provide a sense of security to the resident
- Maintain the resident's daily routine throughout the planning process and move to new home
- Help the individual become acclimated to their new surroundings, again maintaining the resident's daily routine—e.g. a welcoming committee, matching a staff member/volunteer with each individual
- Educate everyone about Transfer Trauma—all staff members, residents, families, volunteers, friends
- Have adequate staff members on duty to continue to meet all residents' needs
- Organize opportunities for residents to discuss concerns and fears—e.g. Support Groups, counseling
- Monitor for signs of Transfer Trauma, never minimize or ignore these characteristics
- Offer support, be empathetic, visit often, and respect the individual's rights

Produced by WI BOALTC Ombudsman Program, April 2005; Resource: "Role of the Long Term Care Ombudsman in Nursing Home Closures," NCCNHR

**Written Response From
Andrea Grothe, RN
Heartland-Preston Inc., Assisted Living Facilities**

General response to the scenario:

This is an excellent scenario. When I read it, I recognized it. We have faced variations of this situation on a number of occasions. I am sure many of you felt the same.

Priority Intervention: The resident and her roommate (also other residents) need to be kept safe. This has been done in this scenario by calling the police.

Alternatively: When the facility began seeing a change in behaviors did they attempt other interventions? In this situation, were there external events that increased the combativeness? Possibly the type of approaches used by staff or specific behaviors by the roommate, other residents, or even family that may have tended to trigger or increase her combativeness. Are there any actions that tend to calm her? Does she enjoy music or a visit from her pastor or a friend of family? Does she do better if she spends time in a common area where there are people around? Were there medical issues that contributed to her behavior (such as UTI, dehydration)? Have lab values been checked to see if they are within normal parameters? Was this a medication issue (Such as medication reactions or interactions or recent medication changes)? Were any psychotropic medications tried (prior to the incident)? Was the resident on any medications for her dementia? If she has Alzheimer's, was she on Namenda or other similar medication?

On the issue of the family and the psychiatric unit:

Intervention: Meet with the family to address and possibly alleviate their concerns, keeping in mind that the resident's needs must be the primary focus. Her new psych meds may need to be changed as they are causing medical issues (edematous ankles) and sedation. The Psych unit should not be refusing to take her back unless they can document they have successfully dealt with her psychiatric issues.

On the nursing home refusing to take her back:

The hospital social worker needs to assist with placement and not pressure the family to do this on their own. Usually families are not as aware of options as a professional should be. A stabilization unit would be an excellent choice for the short term, with a return to the nursing home or a CBRF as a long range goal. The nursing home needs to be open to having this resident return if they can be

reasonably assured that the resident is no longer a danger to herself or others. They will need to monitor closely for future behavior changes.

Final considerations:

It seems that this lady is being let down by the system on every level. No one wants to take responsibility. At each point she is shuffled off to someone else. Sadly, some of our residents have experienced a very similar set of circumstances when they have needed help beyond what our facilities can provide. Somewhere along the line the services of an ombudsman or Adult Protective Services may have been helpful. Also, if she was protectively placed, she would have had the help of her county social worker (note: Chap. 55 is Protective Service System while Chap. 51 is State Alcohol, Drug Abuse, Developmental Disabilities and Mental Health System).

Possible medications: For Alzheimer's—Namenda, Aricept, Reminyl
Antipsychotics—Abilify, Risperdal, Zyprexa, Seroquel