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Nursing Home Residents With Endangering Behaviors and Mental Health Disorders May Be Vulnerable to Facility-Initiated Discharges

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REPORT HIGHLIGHTS

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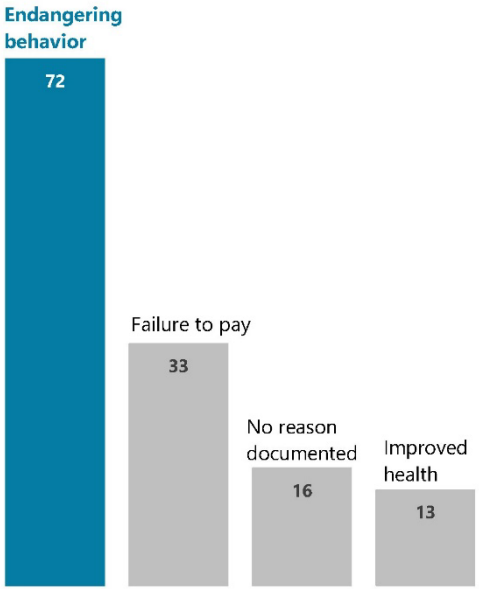
Nursing Home Residents With Endangering Behaviors and Mental Health Disorders May Be Vulnerable to Facility-Initiated Discharges

Why OIG Did This Review

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

What OIG Found

- Nursing homes discharged 72 of the 126 residents in our review because of behaviors that endangered them or others in a facility. In most cases, the residents exhibited aggressive or violent behaviors.
- Prior to discharging these residents, nursing homes most commonly tried changing medications and counseling.
- Residents discharged due to behaviors shared some characteristics such as a mental health disorder and admission for long-term versus short-term care.
- Lastly, most residents in our review were discharged to acute-care hospitals, and 10 residents were discharged to an unknown location, a nonspecific location, or a hotel.



What OIG Concludes

Our findings highlight the challenges that nursing homes face in caring for residents with mental health disorders as well as raise questions about nursing homes' admissions of and capacities to care for these residents. More research is needed into how to provide safe and effective long-term care for residents with mental health disorders and behaviors, especially as the demand for such care grows. To that end, the new Center for Excellence for Behavioral Health in Nursing Facilities, established by the Substance Abuse and Mental Health Services Administration in partnership with CMS, holds promise.

Primer on: Facility-Initiated Discharges in Nursing Homes

- CMS defines a facility-initiated discharge as a discharge that "the resident objects to, or did not originate through a resident's verbal or written request, and/or is not in alignment with the resident's stated goals for care and preferences."

- Nursing homes must document the reason for a discharge in the resident's medical record, and only six reasons are allowed:
    1) The resident's welfare and the resident's needs cannot be met by the facility.
    2) The resident's health has improved sufficiently so the resident no longer needs the services provided by the facility.
    3) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident.
    4) The health of individuals in the facility would otherwise be endangered.
    5) The resident has failed, after reasonable and appropriate notice, to pay.
    6) The facility ceases to operate.

- CMS requires nursing homes to provide a resident with written notice when discharging a resident for one of the six allowable reasons listed above. This written notice must include the location that a resident will be discharged to, among other information.

- Nursing homes must sufficiently prepare and orient a resident to ensure a safe and orderly discharge from a facility.

Sources: 42 CFR § 483.15(c); and CMS, *State Operations Manual* (Rev. Oct. 26, 2022), Appendix PP, Tag 622.

Key findings: Related OIG work on facility-initiated discharges

Concerns Remain About Safeguards To Protect Residents During Facility-Initiated Discharges From Nursing Homes (OEI-01-18-00251), March 2024:

- In most of the facility-initiated discharge cases in our review, nursing homes discharged residents for allowable reasons.
- Nursing homes may have compromised residents' rights and abilities to plan for safe transitions by not adhering to notice requirements for facility-initiated discharges. We found nursing homes in our review often failed to notify residents of their discharges and many nursing homes omitted required information in notices.
- Nursing homes may have impeded State Ombudsman abilities to effectively advocate for residents. We found that even when nursing homes in our review provided a resident with a facility-initiated discharge notice, only about half sent a copy of the notice to an Ombudsman as required.
- Nursing homes struggled to identify facility-initiated discharges, which may present challenges to overseeing these discharges.

Facility-Initiated Discharges Require Further Attention (OEI-01-18-00250), November 2021:

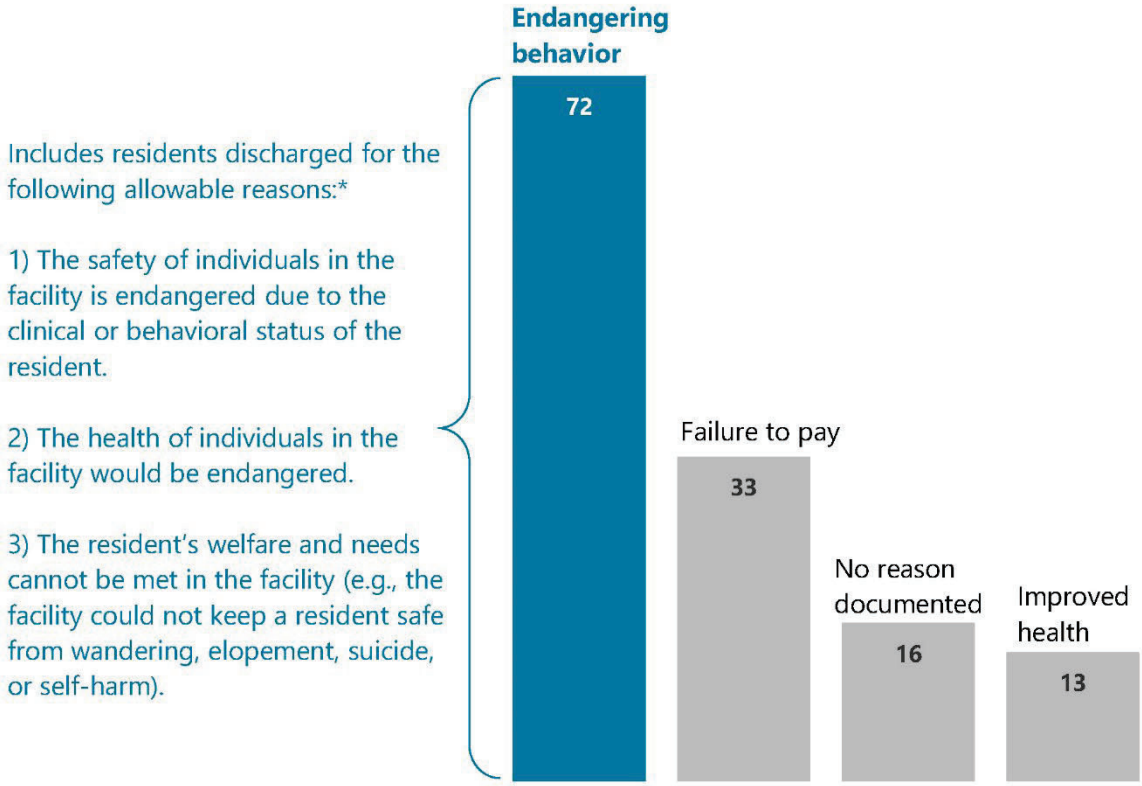
- Fundamental information on facility-initiated discharges is limited. Neither ACL nor CMS collect data on the number of facility-initiated discharges, and many State Ombudsmen do not count or track the notices they receive. This lack of information limits CMS's and ACL's understanding of facility-initiated discharges.
- State Ombudsmen reported that nursing homes do not have a clear understanding of notice requirements for facility-initiated discharges. State Ombudsmen faced challenges while responding to facility-initiated discharges, such as nursing homes sending facility-initiated discharge notices that lacked required information.
- Better coordination and information sharing is needed on these discharges. CMS, ACL, State agencies, and State Ombudsmen all play a role in addressing inappropriate facility-initiated discharges, but each may have different perspectives on regulations and enforcement of facility-initiated discharges. In addition, each has different responsibilities and gathers different information related to these discharges which is not always shared consistently.

Source: OIG summary of related work on facility-initiated discharges.

RESULTS

Nursing homes in our review most often initiated a discharge because the resident's behavior, which was often aggressive, endangered the resident or others in the facility

Exhibit 1: Most of the facility-initiated discharges in our review were due to a resident's endangering behavior (n=126)



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

Notes: In some cases, a nursing home discharged a resident for more than one allowable reason. Similarly, nursing homes may have discharged residents due to endangering behaviors for more than one allowable reason. Therefore, numbers should not be summed. Also, no resident in our review was discharged because a nursing home ceased to operate (the sixth allowable reason).

* Of the 16 residents for whom a nursing home did not document an allowable reason for discharge, 6 had indications in medical records that these discharges were due to endangering behaviors.

We found that nursing homes discharged most of the 126 residents in our review due to endangering behaviors and aligned with 3 of the 6 allowed reasons for facility-initiated discharges. Two of these reasons specifically refer to endangering others in a facility. Nursing homes generally used the third reason—the resident's

needs cannot be met in the facility—in instances when residents endangered themselves through exit-seeking or self-harm behaviors. For example, a nursing home noted that the facility did not have a locked and secure dementia unit to protect a resident who kept getting out through unsecured doors. Some residents exhibited multiple endangering behaviors that aligned with more than one allowable reason for discharge.

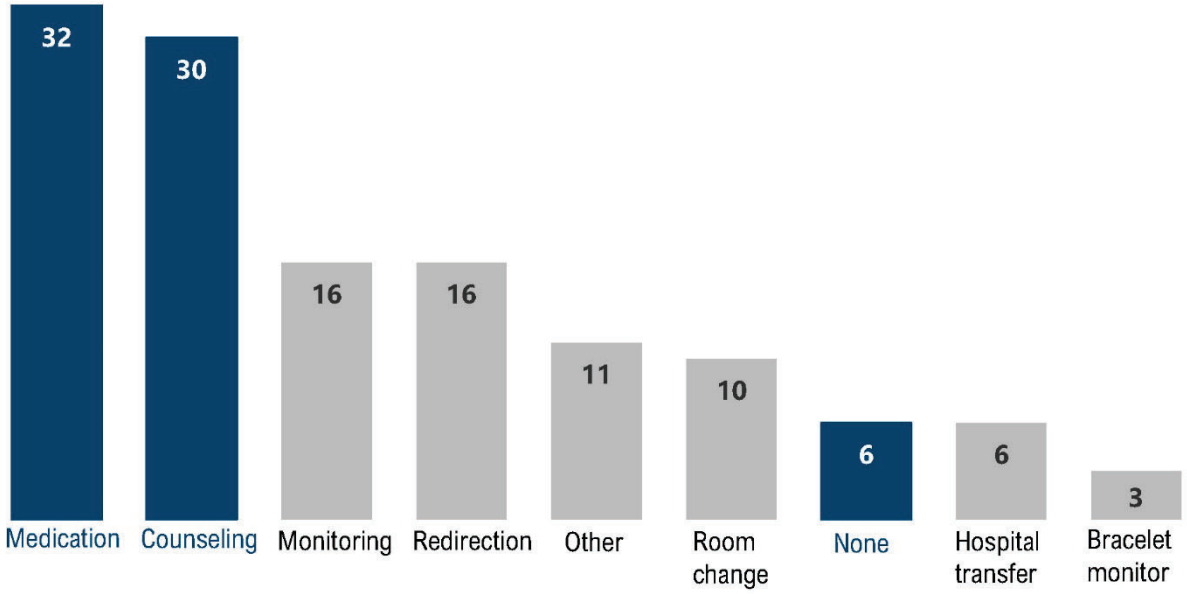
Exhibit 2: Physical and/or verbal aggression was the most common endangering behavior for which nursing homes initiated a discharge for residents in our review (n=72)

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

Note: In some cases, a nursing home discharged a resident for more than one endangering behavior.

Nursing homes discharged 72 of the 126 residents in our review for various behaviors that endangered the resident or others in facilities. In most cases, a resident exhibited aggressive or violent behavior. For example, one nursing home sent a resident to the hospital after the resident hit and bit a certified nursing assistant. Similarly, another nursing home discharged a resident after the resident choked a roommate. And yet another nursing home discharged a resident who threatened to kill another resident. Other examples of behaviors that led to a resident's discharge included wandering or leaving a facility, not adhering to a facility's smoking policy, and being sexually inappropriate.

Exhibit 3: The most common interventions nursing homes tried before discharging a resident due to an endangering behavior were medication changes and counseling (n=72)



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

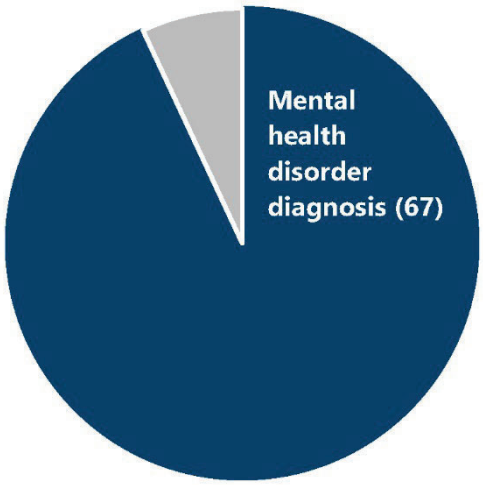
Note: In some cases, nursing homes tried more than one intervention prior to discharging a resident due to behaviors.

Nursing homes in our review tried some different interventions prior to discharging each of the 72 residents due to endangering behaviors. Generally, nursing homes used one or two interventions, but nursing homes documented no interventions for six facility-initiated discharges in our review. The most common interventions nursing homes implemented before discharging these residents were medication changes and counseling. For example, one nursing home documented medicating a resident for agitation and pain to decrease aggressive behavior. Several nursing homes noted that the residents, following aggressive behavior, received counseling such as education and guidance on appropriate behavior, healthy conflict resolution, or positive coping skills. Nursing homes also counseled residents who violated smoking policy.

Some nursing homes used monitoring and redirection as interventions. For example, nursing homes monitored residents via one-on-one staff supervision or by checking residents every 15 minutes. Examples of redirection included a family member bringing in video games, offering snacks, and diversion activity.

Nursing homes in our review used other interventions less frequently, such as room changes, temporary transfers to acute-care hospitals, and wearable bracelets that alert nursing home staff when a resident at risk of wandering or elopement approaches a monitored door.

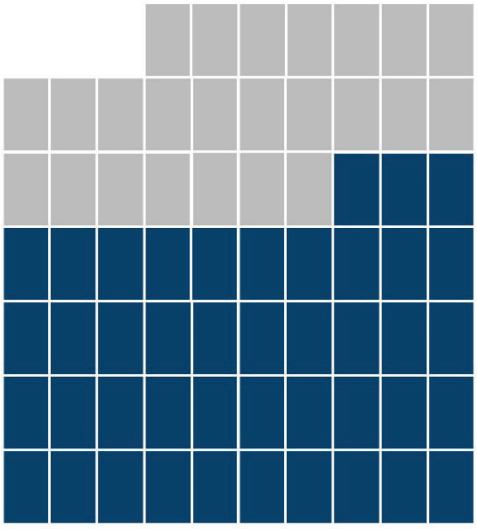
Exhibit 4: Most residents discharged due to endangering behaviors were diagnosed with a mental health disorder (n=72)



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

In our review, the majority of residents who nursing homes discharged due to endangering behaviors had been admitted to a nursing home with a mental health disorder. In fact, mental health disorders were more common among residents discharged due to behavior than among residents discharged for other reasons. Aggressive behavior has been associated with mental health disorders.[1, 2] In our review, we found that 67 of 72 (93 percent) of the residents who were discharged due to behavior had a mental health disorder, compared to 38 of 54 (70 percent) of residents who were discharged for other reasons.

Exhibit 5: Most residents discharged due to endangering behaviors and with a mental health disorder had been admitted to a nursing home for long-term care (n=67)



43 of 67 residents discharged due to behaviors and with a mental health disorder were admitted for long-term care.

Long-term and short-term care[3]

Nursing homes provide both long-term and short-term care. They generally provide long-term care to residents who may have an ongoing health condition or debility that leaves them unable to perform basic activities of daily living, such as dressing or bathing, and need long-term support. In contrast, short-term care is goal-oriented care focused on having a resident return home or resume normal activities. Examples of short-term care provided by nursing homes in our review included rehabilitation to regain physical strength and intravenous antibiotics to treat infection.

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

About two-thirds (43 of 67) of the residents with mental health disorders who were discharged due to behavior had been admitted for long-term care. In other words, nursing homes were aware that these residents had mental health disorders upon admission and had expected to provide care for an extended period of time. In addition, our nurse reviewers noted that many of these residents did not have a significant change in care needs that would prompt a discharge. In fact, nursing homes documented no change in the resident's assessment between admission and discharge for more than half (24 of 43) of the residents discharged due to behavior with a mental health disorder and admitted for long-term care. A change in assessment would include any new physical, behavioral, or psychosocial signs, symptoms, or any exacerbations of chronic conditions.

Although nursing homes cannot anticipate all that a resident will need throughout a stay, nursing homes should be generally familiar with the demands of residents with mental health disorders, especially those who are admitted for long-term care. Our review raises questions about whether nursing homes accurately assessed the behavioral health needs of residents upon admission, as well as whether nursing homes had the appropriate staff, resources, and capacity to care for residents.

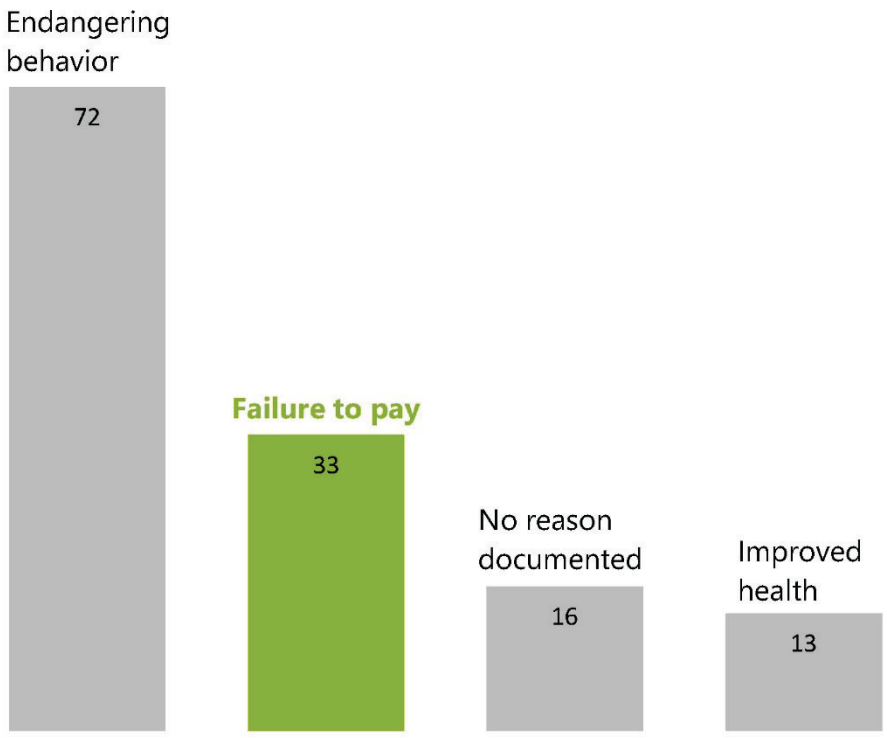
According to CMS, additional factors may contribute to facility-initiated discharges. First, CMS is concerned that hospitals discharging patients are not providing nursing

homes with complete and accurate information about patients. In June 2023, CMS reminded hospitals to provide this information and highlighted information about serious mental illness, complex behavioral needs, and substance use disorders, among other patient information.[4] Second, CMS told us about a lack of State-licensed mental health centers to care for individuals with severe mental illness or substance use disorders. As a result, some individuals have been admitted to nursing homes based on their behavioral needs despite the fact that nursing homes are not intended to care for individuals with a primary diagnosis of severe mental illness or substance use disorders.

Nursing homes also initiated discharges because residents failed to pay for stays

Failing to pay, one of the six reasons nursing homes are allowed to initiate discharges, was the second-most common reason for facility-initiated discharges identified in our review.

Exhibit 6: About one-quarter (33 of 126) of facility-initiated discharges in our review occurred because residents failed to pay for stays (n=126)

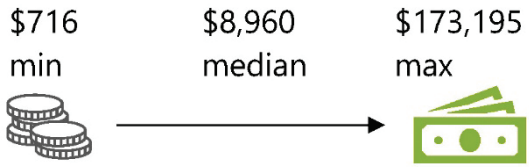


Source: OIG analysis of medical records review data, 2023.

Note: Some residents were discharged for more than one reason.

Most nursing homes in these cases provided residents with a reasonable and appropriate notice, which is what CMS requires when a nursing home initiates a discharge for failure to pay. Nursing homes documented notifying residents of changes in payment status and/or attempted to collect payments in three-quarters (25 of 33) of these discharges. For example, some nursing homes arranged payment plans with residents to collect payments over time. In addition, about half (16 of 33) of the nursing homes that discharged for lack of payment documented that they ensured residents had the assistance to submit any third-party paperwork for payment. For example, nursing homes offered residents assistance in completing and submitting Medicaid applications. One nursing home even took a resident to the bank to obtain statements needed for a Medicaid application.

Exhibit 7: Unpaid balances varied for residents whom nursing homes discharged for failure to pay



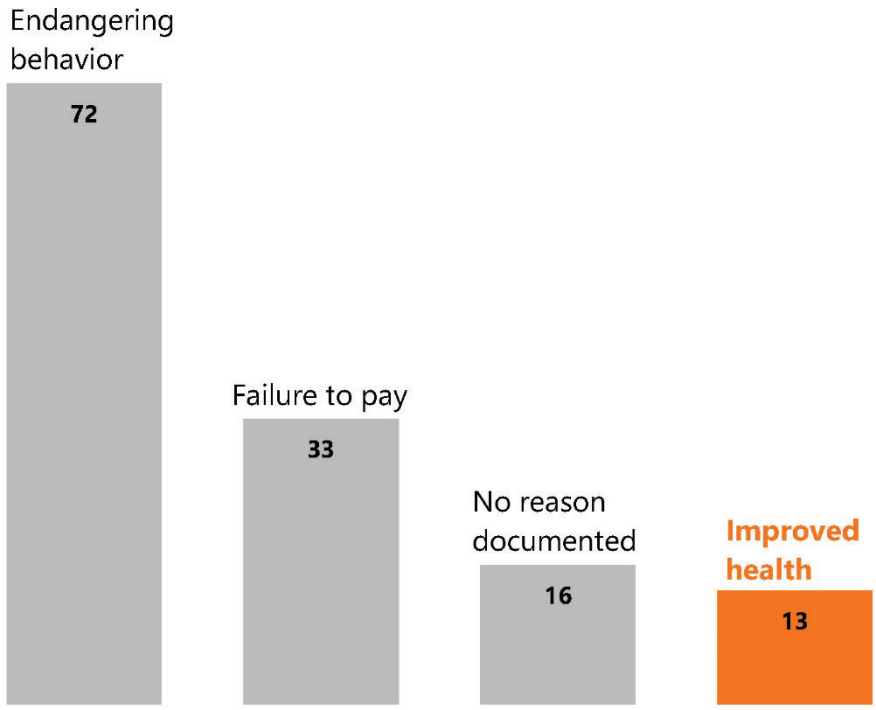
Source: OIG analysis of medical records review data, 2023.

The median unpaid balance among those reviewed was $8,960. But one nursing home discharged a resident for an unpaid balance of $716. At the other end of the range, a nursing home discharged a resident for failure to pay when the unpaid balance reached $173,195. This variability indicates nursing homes have discretion in determining when to discharge a resident for failure to pay for a stay. For reference, the average monthly cost of a semiprivate room in a nursing home is $7,908.[5]

In some cases, nursing homes initiated a discharge because a resident's health improved and the resident no longer needed facility services

Residents' improved health—another allowable reason for a nursing home to initiate a discharge—was not a common reason for discharge in our review.

Exhibit 8: About 10 percent (13 of 126) of facility-initiated discharges in our review were because a resident's health improved and the resident no longer needed facility services (n=126)



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

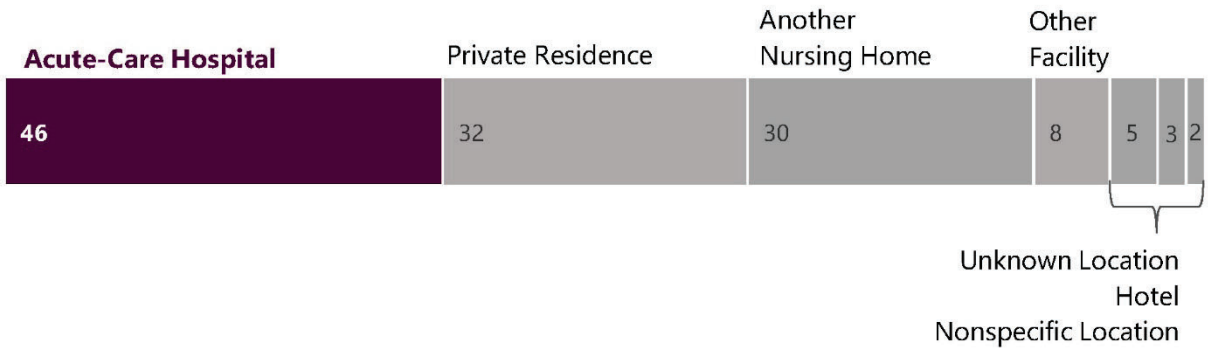
Note: Some residents were discharged for more than one reason.

Our review found sufficient evidence of improvements to support all 13 resident discharges. For example, one resident who needed maximum assistance and was not eating anything by mouth when first admitted could function independently at discharge. The resident could eat by mouth and was ready to continue receiving therapy at home. The medical record for another resident documented that at the time of discharge the resident's overall condition had improved, and the resident was alert and performing all activities of daily living independently. In each of four cases, a resident unsuccessfully appealed a nursing home's assessment that the resident no longer met the criteria for skilled care. In another case, the resident had difficulty securing low-income housing.

Nursing homes discharged most residents in our review to an acute-care hospital

Nursing homes must document discharge locations for residents as part of ensuring a safe and orderly discharge as per requirements. In our review, a hospital was the most common discharge location—for about one-third, or 46, of the 126 residents—after a resident did not return to the nursing home following a temporary transfer for acute care. In almost all of those cases (40 of 46), the nursing home transferred the resident to an acute-care hospital due to endangering behaviors.

Exhibit 9: Most residents were discharged to an acute-care hospital (n=126)



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

The next-most common destinations were private residences (32 of 126) and other nursing homes (30 of 126). Nursing homes discharged a few residents to other facilities, such as an Assisted Living Facility, Adult Foster Care, or a Residential Care Facility.

Nursing homes discharged five residents to an unknown location, two to a nonspecific location, and three to a hotel. For most of these 10 residents, nursing homes did not provide discharge summaries, making it impossible to know whether nursing homes ensured a safe and orderly transition for the residents. For example, a discharge location was not included in a medical record for some residents. Sometimes, initiating a discharge prompted a resident to leave a facility without the nursing home's knowledge or involvement in the transition of care. In one case, the nursing home provided a resident with a facility-initiated discharge notice without a reason for the discharge; the resident left the nursing home and did not return. For the two residents discharged to a nonspecific location, the nursing home only documented that each resident was "discharged to the community."

However, a couple of cases raise concerns about whether the nursing home ensured a safe and orderly discharge for a resident. In each of these cases, the nursing home discharged a resident to a hotel for failure to pay; in one case, the resident was on dialysis—a regular, frequent, and life-sustaining treatment.

CONCLUSION

Insights from this data brief raise some concerns and questions about nursing homes' admission of and capacity to care for residents with mental health disorders. Our findings draw attention to some common characteristics among the facility-initiated discharges in our review: a resident's endangering behavior, mental health disorders, and a transfer to a hospital. Nursing homes should be generally familiar with the demands of residents with mental health disorders, but our findings highlight the challenges that nursing homes face in caring for residents with mental health disorders as well as raise questions about this care. To what extent are nursing homes accurately assessing resident behavioral health needs upon admission? To what extent do nursing homes have the capacity to manage the complex needs of residents with mental health diagnoses, especially when they pose a threat to themselves, other residents, or nursing home staff?

More research is needed into how to provide safe and effective long-term care for residents with mental health disorders and endangering behaviors. Long-term care stakeholders must work to address the shortfalls in behavioral health care, especially as the demand for such care grows, to avoid facility-initiated discharges for these individuals. To that end, the new Center for Excellence for Behavioral Health in Nursing Facilities, established by the Substance Abuse and Mental Health Services Administration in partnership with CMS, holds promise. The center aims to provide technical support, resources, and training to nursing homes to care for residents with mental health needs and substance use disorders.[6]

These insights and the concerns we identified in our companion reports highlight that more needs to be done to protect nursing home residents from potentially traumatic and unsafe facility-initiated discharges. This data brief identifies residents who are vulnerable to these discharges and is a call to action for better long-term care for people with mental health disorders. Our two other reports highlight weaknesses in safeguards protecting nursing home residents from inappropriate discharges as well as concerns about nursing homes' inability to identify facility-initiated discharges and understanding of and compliance with Federal requirements. Our recommendations in those reports point to opportunities to strengthen safeguards to ensure residents' rights and safety and prevent inappropriate discharges; and include collecting and analyzing data on facility-initiated discharges and notices, training nursing homes, assessing the effectiveness of Federal enforcement activities, and increasing coordination and data sharing among Federal and State partners.[7, 8]

METHODOLOGY

Scope

We considered facility-initiated discharges from Medicare- and Medicaid-accepting nursing homes in our review. Our data refer to the last 6 months of calendar year 2019, which is the latest data available not overlapping the COVID-19 pandemic.

Data Source

Our review includes data from medical records for a sample of residents who were subject to facility-initiated discharges between July and December 2019.

Sample Selection

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

Analysis

Nurses and physicians reviewed the medical records of 126 residents that nursing homes reported as facility-initiated discharges during our study's scope. We requested medical records directly from the nursing homes. The nurse and physician reviewers followed structured protocols that we developed in consultation with the reviewers and physician experts in long-term care. Among the protocols were: questions about documentation requirements; support in medical records for the reason for a discharge; and the resident's clinical status and conditions. The goal of the medical record reviews was to determine whether a nursing home followed Federal regulations for initiating the discharge of a resident.

We analyzed the results of the nurse and physician reviews for the 126 facility-initiated discharge cases within our sample. Specifically, we examined the results from open-ended questions regarding why a nursing home initiated the discharge of a resident. If the open-ended responses included an endangering behavior—such as aggression, wandering, or self-harm—we categorized the discharge reason for that

resident to be due to endangering behaviors. A resident could have more than one reason for discharge. In addition, we examined responses to open-ended questions about a resident's diagnoses upon admission, nursing home efforts to prevent the discharge, and circumstances surrounding the discharge. We conducted qualitative analysis and categorized responses by theme to identify patterns across the residents in our sample.

We also examined the nurse review results for questions on whether the cases followed CMS documentation requirements and guidance in medical records, such as ensuring a resident has assistance with third-party paperwork for payment and recording a discharge location. We also analyzed nurse review results for questions about the reason for discharge and whether the nursing home provided support for the reason.

See Detailed Methodology in our companion report (OEI-01-18-00251) for further information.[9]

Limitations

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

Standards

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

ACKNOWLEDGMENTS AND CONTACT

Acknowledgments

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

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

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ENDNOTES

[1] Abin Varghese et al., *Pattern and Type of Aggressive Behavior in Patients with Severe Mental Illness as Perceived by the Caregivers and the Coping Strategies Used by Them in a Tertiary Care Hospital.* Archives of Psychiatric Nursing 30 (2016), pp. 62–69.

[2] J.B. Hessler et al., *Behavioural and psychological symptoms in general hospital patients with dementia, distress for nursing staff and complications in care: results of the General Hospital Study.* Epidemiology and Psychiatric Sciences 27 (2018), pp. 278–287.

[3] Bella Vista Health Center, Difference Between Short-Term Care and Long-Term Care. Accessed at https://www.bellavistahealth.com/blog/2017/6/26/difference-between-short-term-care-and-long-term-care on July 11, 2023.

[4] CMS, *QSO-23-16-Hospitals, Requirements for Hospital Discharges to Post-Acute Care Providers.* Accessed at https://www.cms.gov/files/document/qso-23-16-hospitals.pdf on Aug. 28, 2023.

[5] Genworth Financial, Inc., *Cost of Care Survey.* Accessed at https://www.genworth.com/aging-and-you/finances/cost-of-care.html on June 22, 2023.

[6] Center of Excellence for Behavioral Health in Nursing Facilities website. Accessed at https://nursinghomebehavioralhealth.org on June 22, 2023.

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

[8] *Concerns Remain About Safeguards to Protect Residents During Facility-Initiated Discharges From Nursing Homes* (OEI-01-18-00251), Mar. 2024.

[9] *Concerns Remain About Safeguards to Protect Residents During Facility-Initiated Discharges From Nursing Homes* (OEI-01-18-00251), Mar. 2024.