WISCONSIN DEPARTMENT *of* HEALTH SERVICES

Resident Relocation Manual

For Nursing Homes, Community-Based Residential Facilities, and Intermediate Care Facilities for Individuals With Intellectual Disabilities

P-01440 (06/2024)

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Introduction

This manual offers guidance and direction to nursing homes, Intermediate Care Facilities for Individuals With Intellectual Disabilities (ICF-IID), and Community-Based Residential Facilities (CBRF) that are relocating residents under the requirements of Wis. Stat. ch. 50.

The intent of the statute, as well as this manual, is to promote the safe and orderly transfer of residents in a way that diminishes the effects of the Relocation Stress Syndrome (RSS), also known as "transfer trauma."

The intent of the statute, as well as this manual, is to promote the safe and orderly transfer of residents in a way that diminishes the effects of the Relocation Stress Syndrome (RSS), also known as "transfer trauma."

This Resident Relocation Manual explains the basic requirements of the Wis. Stat. ch. 50 Resident Relocation Plan. The Resident Relocation Manual is intended to be a resource. The specific statutory requirements for the submission and implementation of a facility's Chapter 50 Resident Relocation Plan can be found among the referenced regulations located in this manual. A thorough review and understanding of the regulations related to resident relocation during the facility's decision-making process is required.

A facility should communicate with the Wisconsin Department of Health Services (DHS) early in the decision-making process because the relocation of residents involves the coordination of agencies at the local, county, and state level. These agencies become members of the State Relocation Team that is established to oversee and monitor the resident relocation process.

Relocation Team members have divergent roles and responsibilities. Facility staff may have little to no prior involvement with this type of intense multi-agency team process. The common ground for all team members is their ethical and legal responsibility to work together to provide the relocating resident with information on how to access and obtain resources, how to provide options for living arrangements, how to collaborate in the discharge planning process, and how to ensure

assistance with the successful implementation of the resident's discharge plan.

The flowchart on the next page is designed to assist the facility in determining if a Chapter 50 Resident Relocation Plan may be required.

Chapter 50 Resident Relocation Requirements

Contact the Department of Health Services (DHS) Division of Quality Assurance (DQA) and Division of Medicaid Services Relocation Coordinator for consultation in **all** the situations below.

When Chapter 50 Resident Relocation Requirements Might Apply

Facility intends to change the means of reimbursement accepted *and* 5% or five or more residents will be discharged.*

Facility intends to close *and* 5% or five or more residents will be discharged.*

Facility intends to change the type or level of services provided *and* 5% or five or more residents will be discharged.*

* Chapter 50 resident relocation requirements apply when at least five residents or 5% will relocate, whichever is greater.

Next Steps:

- **Review all** state and federal regulations related to discharge.
- **Review** resident relocation manual.
- **Submit** resident relocation plan to DHS.
- **Obtain** approval of resident relocation plan before discharging residents.
- **Follow** DHS directives related to relocation of residents in a safe and orderly manner in order to prevent the effects of resident relocation stress syndrome over the specified timeframes found in Chapter 50.

When Chapter 50 Resident Relocation Requirements Might Not Apply

Facility intends to reduce the census by natural attrition *and* no involuntary discharges are anticipated.

Facility intends to replace or renovate existing physical structure *and* no involuntary discharges are anticipated.

Next Steps:

- **Contact** the Board on Aging and Long Term Care Office of the State Long Term Care Ombudsman for technical assistance.
- **Advise** DQA and follow directives accordingly.

Contact Information

Bureau of Nursing Home Resident Care
www.dhs.wisconsin.gov/dqa/bnhrc-regionalmap.htm

Bureau of Assisted Living
www.dhs.wisconsin.gov/dqa/bal-regionalmap.htm

Division of Medicaid Services Relocation Coordinator
www.dhs.wisconsin.gov/relocation/index.htm

Board on Aging and Long Term Care
longtermcare.wi.gov/Pages/Home.aspx

Remember: When the change at the facility results in less than five residents or 5% of residents being discharged, other state and federal regulations apply. Review all regulations, advise DQA, and follow directives accordingly.

WISCONSIN DEPARTMENT of HEALTH SERVICES

Division of Medicaid Services
P-02088 (07/2023)

Additional Explanations and Clarifications for Determining When the Chapter 50 Resident Relocation Requirements Apply

A Resident Relocation Plan is required when a facility intends to relocate or discharge five or more residents or 5% of its resident population for the following reasons.

Closing

When a facility makes a decision to close, the facility is required by Wis. Stat. § 50.03(14)(c)7 to notify DHS in writing of its intention to close and relocate residents; a Resident Relocation Plan must be submitted whenever five or more residents or 5% of residents will be relocated.

Changing the Type or Level of Services Provided

A facility may decide to change the type or level of services it provides and as a result is no longer able to meet the needs of those residents previously served. Examples may include, but are not limited to:

- A facility specializing in the care and treatment of persons with mental illness may decide to change its service delivery to caring for older persons with memory loss and dementia.
- A facility may choose to change its licensure from a skilled nursing facility to a CBRF.

When a facility makes a decision to change the type or level of services, the facility is required by state law to notify DHS in writing of its intention to change the level of services provided and to relocate residents. A Resident Relocation Plan must be submitted whenever five or more or 5% of resident population will be relocated. A facility may not discharge a resident if still able to adequately meet their needs and the resident still qualifies to receive the new level of care or services.

Changing the Type of Reimbursement Accepted

A facility may decide to change the means of reimbursement accepted and as a result is no longer able to receive payment for

DID YOU KNOW?

A Resident Relocation Plan is required when a facility intends to relocate or discharge five or more residents or 5% of its resident population for the reasons shown at left.

the person previously funded by a particular source. Examples may include, but are not limited to:

- A facility no longer accepts public funding as a payer source.
- A skilled nursing facility no longer chooses to maintain certification for either Medicare or Wisconsin Medicaid.

When a facility decides to change the means of reimbursement accepted, the facility is required by state law to notify DHS in writing of its intention to change the means of reimbursement to be accepted and to relocate residents. A Resident Relocation Plan must be submitted if five or more or 5% of residents, whichever is greater, will be relocated.

DID YOU KNOW?

A Resident Relocation Plan may not be required when a facility intends to relocate residents for other reasons.

Downsizing by Natural Attrition

When a facility intends to reduce the number of residents it serves by natural attrition, it will allow the census to decline to the desired level through normal day-to-day discharge occurrences. These discharges are most often due to death or resident decisions to return to their community homes, to relocate to another region of the state or country, or to transfer to another provider type. Downsizing by natural attrition is indefinite, and it could take many months or years. The facility must not make any additional or concerted effort to encourage resident discharges. Residents have choices and may choose to stay at the facility. Residents cannot be involuntarily discharged.

Replacement Facilities

When a facility renovates or builds a new building to replace its physical location, the facility is not typically required to submit a Chapter 50 Resident Relocation Plan as no resident discharges are anticipated as a result. The facility must advise the Division of Quality Assurance (DQA) and follow DQA directives. The facility is encouraged to contact the Board on Aging and Long-Term Care (Ombudsman program) for resources and information about replacement relocations.

Any movement of a resident presents the potential for the person to experience relocation stress. The facility must take steps to adequately inform and prepare the resident, subsequent caregivers, and all other interested parties for transfer whether

the resident is moving within a current residence or to a new setting.

Technical Assistance

The contents of this Resident Relocation Manual are designed to guide facilities in developing an approvable resident relocation plan under applicable statutes and codes. Included in the manual are sample forms and templates that will assist facilities in drafting their plan. Consultation and technical assistance are always available to facilities by contacting the Division of Medicaid Services (DMS) Relocation Coordinator by phone at 608-267-7286, email at DHSResidentRelocations@dhs.wisconsin.gov, or mail at the following address:

Included in this manual are sample forms and templates that will assist facilities in drafting their plan.

Department of Health Services
Division of Medicaid Services
Bureau of Quality and Oversight
Attn: Relocation Coordinator
1 W Wilson St Rm 434
Madison WI 53703

Section I: Initial Contact With Department of Health Services Division of Medicaid Services

It is the role of DMS to monitor the entire resident relocation process. This includes, but is not limited to:

- Ensuring facilities understand Wis. Stat. ch. 50 and applicable Wisconsin Administrative Code as they relate to resident relocation and that these facilities are in compliance with its requirements.
- Approving the Resident Relocation Plan.
- Ensuring resident rights are protected, resident-centered relocation occurs at the systems level as well as at an individual level, and the residents' right to choose is respected and honored.
- Leading the State's Resident Relocation Team.
- Collaborating with Aging and Disability Resource Centers (ADRCs), managed care organizations (MCOs), IRIS (Include, Respect, I Self-Direct) independent consultants, counties and county waiver programs, and advocacy agencies.
- Strategizing with relocation team members and providing expertise to remove barriers; if any, impeding a person's relocation.
- Confirming a plan for resident monitoring and staff training regarding resident relocation stress syndrome (RSS).
- Confirming with the facility administrator regarding the facility staff resources that will be allocated for discharge planning and the relevant experience of designated facility staff.
- Determining with the facility administrator that additional staff resources will be available if needed to both operate the facility and manage resident relocation assignments.
- Collaborating with the DQA.
- As indicated, conducting follow-up outcome evaluations of relocated residents.
- Conducting a "lessons learned" meeting after resident relocation and facility closure to identify strengths of the process and areas that need further strengthening.

Initial Facility/Department Meeting

When the facility contacts DMS regarding its intent to submit a Resident Relocation Plan, the Division Resident Relocation Coordinator will schedule an initial meeting with the facility representatives.

Purpose of Initial Meeting

- Review the Wis. Stat. ch. 50 requirements for a facility Resident Relocation Plan along with all other relevant state and federal regulations.
- Discuss the State Resident Relocation Team roles, responsibilities, and composition.
- Discuss the public long-term care (LTC) delivery system including Family Care, Family Care Partnership, Program of All-Inclusive Care for the Elderly (PACE), IRIS, and county waiver programs.
- Confirm the facility's commitment to preserve resident rights.
- Inform DMS of potential legal, financial, personnel, or operational concerns that may affect the successful relocation of all facility residents.
- Ensure the facility will mitigate RSS for residents, families, staff, and other involved persons.
- Answer questions.
- Confirm relocation process timelines.

Timelines and Relocation Plan Submission

Timing of the facility's submission of the Resident Relocation Plan needs to take into consideration multiple factors including Wis. Stat. § 50.03(14)(e), which provides that the effective date of the closing or approved change may not be earlier than:

- 90 days from the date a relocation plan is approved by DHS if five to 50 residents are to be relocated.
- 120 days from the date a relocation plan is approved by DHS if more than 50 residents are to be relocated.

Note: The facility must remain open until each resident is properly relocated, which may require more than 90 or 120 days. If all residents are properly relocated prior to the closing date, the facility may close prior to the approved date.

DID YOU KNOW?

The effective date of the closing or approved change may not be earlier than:

- 90 days from the date a relocation plan is approved by DHS if five to 50 residents are to be relocated.
- 120 days from the date a relocation is approved by DHS if more than 50 residents are to be relocated.

Submission

- The Resident Relocation Plan may be submitted to DMS via email at DHSResidentRelocations@dhs.wisconsin.gov.
- Residents' personal and health information must be protected at all times. Contact the DMS Relocation Coordinator for resident roster submission instructions.
- Alternative methods of submission include U.S. Postal Service, commercial delivery service, or hand delivery.

Residents' personal and health information must be protected at all times. Contact the DMS Relocation Coordinator for resident roster submission instructions.

Chapter 50 Resident Relocation Plan Review and Approval Process

The review process begins upon submission of a facility's Resident Relocation Plan to DMS.

The facility may be contacted to clarify submitted information or to request additional information. The facility will be notified in writing when the plan is approved.

Planning for or implementing any resident's discharge must not be initiated until after the facility's Resident Relocation Plan has been approved by DMS.

Division of Medicaid Services Plan Review: Approval or Denial Protocols

DMS must respond within 10 calendar days of receipt of a facility Resident Relocation Plan pursuant to Wis. Stat. § 50.03(14)(d). DHS' failure to provide a response within 10 days results in automatic approval of the plan.

The DMS Resident Relocation Coordinator will consult with the facility until all components of the plan are complete and approved. If the Resident Relocation Coordinator has contact with the facility to discuss aspects of the plan that are incomplete, or do not meet the intent of the statute, the 10-day approval time restarts from the date DMS receives an amended Resident Relocation Plan from the facility.

DMS will conduct its review of the plan based on statutory criteria and in consultation with other state agencies and members of the State Relocation Team. The review will

determine whether all statutorily required components are present and satisfactory.

Section II: Resident Relocation Plan Requirements

Resident Relocation Plan Submission Form

https://www.dhs.wisconsin.gov/forms/f02282a.docx

The Resident Relocation Plan must include a description of steps the facility will take in the following areas:

- Notifications to residents, family members, staff, vendors, and stakeholder organizations
- Relocation stress syndrome prevention and mitigation
- Resident announcement meeting
- Person-centered relocation planning including:
  - Initial relocation planning conferences
  - Referrals and assessments
  - Tours, visits, and relocation orientation activities
  - Discharge and other required notices
  - Final discharge planning conferences
  - Discharge summaries and post discharge plans
  - Moving
  - Facility follow-up
- Complaint, grievance, and appeal follow-up
- Maintaining adequate staffing and provisions

A resident roster must also be submitted at the time the Resident Relocation Plan is submitted.

Facility Relocation Plan Resident Roster and Individualized Relocation Plan Submission Form

https://www.dhs.wisconsin.gov/forms/f02282.xlsx

The resident roster must include:

1. Resident demographic information
2. Information regarding each resident's current levels of care
3. Brief description of special needs or conditions
4. Information about the resident's legal or decisional status
5. Individualized relocation plan for each resident

The resident individualized relocation plan should be developed with the resident over time as part of the relocation process. Review the link above for additional details and requirements.

Section III: Resident Relocation Team

Goal of the State Relocation Team

The State Relocation Team Coordinates and Oversees Available Resources to Ensure Safe and Orderly Transfer and Positive Outcomes for All Relocation Residents
• Ensuring a resident-centered focus throughout the relocation process.
• Remaining focused on the best outcomes for the residents while respecting their individual right to choose an appropriate alternate placement.
• Recognizing the impact on resident and staff relationships.
• Recognizing the impact on the community and its residents.
• Recognizing the impact of RSS on residents, families, and staff.
• Providing support to receiving facilities and community service providers to assist them in mitigating the effects of RSS on residents and families.
• Encouraging creative and flexible problem solving.
• Prioritizing reliable and inclusive communication systems with all stakeholders involved.
• Conducting business in a professional and collaborative manner.
• Evaluating the completed process to establish best practices and address areas of the relocation process that need improvement.

Roles and Responsibilities

DHS is authorized to install a Resident Relocation Team under Wis. Stat. ch. 50. The DMS Relocation Coordinator will determine the composition of the State Relocation Team. Each of the State Relocation Team members has a specific role to assume in the resident relocation process. The following includes a summary of the state relocation team goals and basic descriptions of each team member's role. Team members may change during the relocation process as resident and client groups change. The DMS Relocation Coordinator will facilitate the continuity of the team process and coordinate all team activities.

Team Member Roles		
Facility	**County**	**Advocacy Organizations**
Facility • Notifies DHS in a timely fashion of the intent to close, change, or relocate five or more residents or 5% of residents, whichever is greater. • Submits a Resident Relocation Plan to DHS for review and approval before beginning the relocation process. • Continues to provide adequate care and treatment until each resident has relocated to a suitable alternate setting within statutory timeframes. • Follows all directives of Chapter 50 and the approved relocation plan. • Works in collaboration with team members to ensure all residents have the choice of an appropriate alternate setting and are properly relocated to their new home. • Coordinates and facilitates planning conferences and other relocation activities in cooperation with involved MCO or case management agency. • Makes appropriate referrals and facilitates assessments. • Coordinates, facilitates, and supports residents on tours and visits to	• Formally notified of the facility's intent to transfer residents. • May participate on the State Relocation Team to ensure the county's responsibilities for protecting the health, safety, and welfare of at-risk adults are met. • Ensures Adult Protective Services are involved in legal issues pertaining to their jurisdiction. • Provides technical assistance regarding issues related to guardianship and notice of transfer of protective placement. ***Residents Receiving Support Through Community Aids*** Participate in weekly relocation team meetings to provide updates to the relocation team regarding: • Meetings that have taken place between the county, resident, and/or legal representative and provider. • The resident's and/or legal representative's preferences related to the living arrangement and identify barriers, if any, to achieving the	***Office of the State LTC Ombudsman*** For persons 60 or more years of age. ***Disability Rights Wisconsin*** For persons under the age of 60. ***Both Organizations*** • Formally notified of the facility's intent to transfer residents. • Reviews and makes recommendations prior to approval of the facility's resident relocation plan. • Participates in the orientation meeting and presents role at resident and family informational meetings. • Actively participates on the State Relocation Team to monitor resident relocation plans and advocates for individual residents. • Represents the interests of residents to promote their choices and to assist them to assert their preferences. • Remains available to residents, their families, and authorized decision-makers to provide assistance and information regarding the requirements for relocation and

Team Member Roles		
Facility	**County**	**Advocacy Organizations**
potential alternate living arrangements. • Participates in weekly relocation team meetings to report on the condition and relocation activities for each resident. • Provides an updated resident roster to DHS before each team meeting. • Reports on the status of the facility, staffing levels, and provisions. • Coordinates, facilitates, and supports resident with the physical transfer of the individual and their belongings. • Assists with packing, unpacking, and settling into new settings as allowed. • Assures a safe and orderly transfer and reports on the details of the move and the condition of the resident. • Follows-up and reports back to team regarding adjustment. • Responds to all inquiries or concerns voiced about issues relating to ongoing care or to complaints about the relocation process.	resident's choice of living arrangement. • A list of providers that have been contacted, including the name and location. • Details surrounding the discharge plan. • Updates on how the resident is adjusting once the resident has been moved.	discharge planning and about options for alternative living arrangements. • May have a regular physical presence at the relocating facility to monitor the residents' satisfaction with care, treatment, conditions, and the relocation process. • May participate in planning conferences or other meetings involving residents or their authorized decision-makers. • May assist in appeals or file formal complaints with the regulatory agencies and may participate in complaint surveys as arranged with the DQA. • Works with DHS to continually improve the relocation process.

Team Member Roles		
Managed Care Organizations	**Division of Medicaid Services**	**Other State Agencies**

Managed Care Organization
• Are formally notified of the facility's intent to transfer residents.
• May participate in the orientation and informational meetings.
• Meet with members to assess needs and preferences for alternate living arrangements and develop a relocation plan.
• Participate in all planning conferences and conversations relating to the member's relocation plans.
• Communicate options and collaborate with the facility in making referrals to suitable sites.
• Arrange necessary services and supports in new settings as well as supports in the physical transfer of the member and their belongings.
• Participate in weekly relocation team meetings to provide updates to the team regarding:
  ○ Meetings having taken place between the MCO, resident, legal representative, and provider.
  ○ The resident's or legal representative's preferences for living arrangements and identify
	Relocation Coordinator Role
	• Reviews and approves resident relocation plans.
	• Provides technical assistance to facilities.
	• Serves as a resource to all members of the State Relocation Team.
	• Facilitates and participates in the orientation and informational meetings.
	• Monitors the development of resident relocation plans and ensures plans are implemented and timely progression is maintained.
	• Ensures the ultimate goal of properly relocating all residents.
	• Ensures proper follow-up visits and evaluations for relocating residents who may have experienced unanticipated outcomes.
	• Monitors the status of onsite facility resources, including staffing, supplies, security, and staff morale.
	• Reports serious regulatory concerns to the DQA.
	• Convenes a final relocation team meeting to debrief the transition with team members.
		Office for Resource Center Development
		• Informs the local ADRC of the relocation plan approval.
		• Provides technical assistance to the ADRC in preparation for participation in the informational meeting and ongoing relocation team meetings.
		• Reviews resident roster and confirms financial and functional eligibility status.
		• Participates in ongoing relocation team meetings as needed.
		
		Area Administration
		• Facilitates joint planning and sharing of resources when more than one county is involved with the relocation process.
		• Encourages informal discussion and resolution of residency disputes, inter-county or inter-state transfers, or venue changes. If informal discussions cannot resolve these, area administration can make a formal determination.
		• Acts as a liaison between the State Relocation Team and the counties

Team Member Roles		
Managed Care Organizations	**Division of Medicaid Services**	**Other State Agencies**
barriers, if any, to achieving the member's choice. ○ A list of providers that have been contacted, including the name and location. ○ Details surrounding discharge plan. • Provide updates on how the resident is adjusting once the member has been moved. • Follow up and report updates to DMS Relocation Coordinator within 30 days of the member's move. • Continue to monitor and report on any outstanding issues.	• Works with stakeholders to continually improve the relocation process. ***Bureau of Quality and Oversight*** • Provides quality and oversight of MCOs. • The Member Care Quality Specialist works with their assigned MCO to ensure the MCO is appropriately planning for, and if necessary, adding capacity to serve members. • Participates in the orientation, informational, and ongoing meetings as needed. • Assists with problem solving with the MCO. • Provides technical assistance to the MCO.	who have legal and/or financial responsibility for individuals to be relocated. ***Division of Care and Treatment Services*** • Cross-references the list of residents to be relocated to the Preadmission Screening and Resident Review (PASRR) database for nursing homes. • Reinforces that persons who are determined through the PASRR process to not need nursing facility placement are to be discharged to a community placement. • Offers limited consultation and assessment services to help determine the needs and treatment approaches for persons who have a mental illness and who may benefit from a community placement or who have not responded well to treatment.

Team Member Roles	
Aging and Disability Resource Center	**Division of Quality Assurance**
Aging and Disability Resource Center • Is formally notified of the facility's intent to transfer residents. • Participates in the orientation meeting and presents role at a resident and family informational meeting. • Contacts any individual/guardian who is not currently enrolled in an LTC program by letter or phone call to explain the role of ADRC and offer LTC options counseling. • Participates in weekly relocation team meetings to report contact made with residents and decisions regarding options counseling. • Provides basic services including information and assistance, options counseling, benefits counseling, and assistance with eligibility and enrollment in publicly funded LTC.	• Is formally notified of the facility's intent to transfer residents. • May participate in the orientation and informational meetings. • Actively participates on the State Relocation Team to monitor overall conditions at the facility and for compliance with all applicable state and federal laws and regulations.

Family and Guardian Role and Responsibilities

Residents, legal representatives, and family members play an important role in the relocation process as well. Residents and legal representatives should be at the core of the decision-making and relocation planning process.

If the resident can make independent decisions, family members can offer support and guidance to the resident in the decision-making process. If the resident is unable to voice their preferences for relocation, active participation by family members and legal decision-makers is necessary for successful placement.

Residents and legal representatives should be at the core of the decision-making and relocation planning process.

The family representatives and/or the legal guardian can perform their roles by:

- Attending the resident and family meeting to obtain information about the reasons relocation from the facility is necessary, options available for relocation, and assistance available from local agencies.
- Communicating the resident's needs and preferences to the facility designee by actively participating in the discharge planning process.
- Visiting potential residences to discuss the resident's needs and determining if the residence would be an appropriate selection.
- Indicating level of care and residence preference when the resident is not able to.
- Supporting the resident emotionally during the relocation process by visiting more often if possible.
- Assisting the resident when feasible to visit potential residences and helping make a final choice.
- Completing the admission process at the new residence prior to relocation, if applicable.

Section IV: Staffing and Provisions

In deciding to close or otherwise relocate residents in accordance with Wis. Stat. § 50.03, a facility must allocate adequate time and resources to ensure that all residents are relocated in a safe and orderly manner to the most appropriate setting in terms of quality, services, and location.

The facility must have measures in place to ensure that the administrator's and/or facility manager's duties and responsibilities are carried out throughout the duration of the resident relocation process of a minimum of 90–120 days.

The administrator's and/or facility manager's duties and responsibilities include:

- Notification to facility staff, vendors, and contractors of the impending closure or need for resident transfers to ensure continuity of care and that necessary goods and services are provided until all residents have relocated
- Designation of the primary contact(s) responsible for the daily operation, oversight, and management of the facility during the process
- Articulation of the roles and responsibilities of the facility's owners, administrator, their replacement(s), or temporary managers/monitors during the process
- Identification of all sources of funding to assist in maintaining the facility's daily operations until all residents are safely relocated
- Adequate provisions for ongoing operations and management of the facility and its residents and staff during the relocation process that include:
    - Payment of salaries and expenses to staff, vendors, contractors, etc.
    - Continuation of appropriate staffing to meet the needs of all residents
    - Ongoing assessment of each residents' care needs and the ongoing provision of necessary services and care including the provision of medications, services, supplies and treatments as ordered by the resident's physician/practitioner
    - Ongoing accounting, maintenance, and reporting of resident personal funds

- The labeling, safekeeping, and appropriate transfer of residents' personal belongings (such as clothing, medications, furnishings) at the time of transfer or relocation, including contact information for missing items after the facility has closed
- The maintenance of the physical plant
- The provision of food and all other basic necessities

Actions need to be taken to avoid the possibility of insufficient facility staff. Many facilities provide an incentive to employees agreeing to remain on staff throughout a relocation process to maintain consistent and familiar staffing while decreasing the stress to all involved residents. In addition, depending on the number of employees, a facility must follow the legal notice requirements for employees.

Section V: Relocation Team Meeting Process

Announcement to Staff

Timing

After relocation plan approval, the staff announcement should be done within the same timeframe that residents and legal representatives are made aware of the need for relocation.

Purpose

Facility staff should be informed of the facility's plan for closure and/or plans to otherwise relocate residents. The announcement includes elements of the facility plan to address staff stress due to job implications.

Initial Orientation Meeting for State Relocation Team Members

Timing

This meeting should occur prior to the informational or announcement meeting.

Purpose

The purpose of the initial relocation team orientation meeting is to introduce the State Relocation Team members to one another and to set the stage for a successful resident relocation process. This meeting provides each team member an opportunity to clearly articulate their role and scope of responsibility as well as a chance to discuss and coordinate parallel planning activities with each other.

The purpose of the initial relocation team orientation meeting is to introduce the State Relocation Team members to one another and to set the stage for a successful resident relocation process.

Additional purposes of the orientation meeting include:

- Updating the assembled team members to confirm the plan to relocate residents from the facility and discussing an agenda and format of a resident and family announcement or informational meeting
- Discussing a timeline for resident relocations and setting a format and frequency for ongoing relocation team meetings

- Informing all relocation team members, including those from the facility, of expectations for a resident-centered relocation planning process and addressing any questions or concerns they might have about that process
- Discussing rights of residents, including the right to be kept adequately informed and prepared for relocation though planning conferences and to have referrals made on their behalf to other care providers such as referrals to an ADRC for options counseling and possible enrollment into an MCO or other programs (Residents have the right to be involved and to choose to relocate to a suitable alternate living arrangement in the least restrictive/most integrated setting and to then be provided with direct assistance in transferring there.)
- Discussing the role of the advocates in monitoring for the exercise of those rights, representing the interests, and promoting the preferences of the residents to the team
- Discussing the role of MCOs and any other case-management agency representatives and how it impacts the relocation plans of their members and the responsibilities of other State Relocation Team members
- Discussing processes for addressing any implications of or potential issues surrounding the residents' legal or decisional status and discussing methods for communicating with and notifying residents or their properly authorized substitute decision-makers (and other interested parties including courts and county agencies)
- Discussing measures to be taken for the mitigation of RSS or transfer trauma (TT) or any other areas of the relocation process needing clarification
- Affording the facility administrator the opportunity to update the State Relocation Team on the current operational status as it relates to available resources and potential barriers to supporting residents in successfully relocating

Informational/Announcement Meeting

Timing

This meeting should occur approximately one week following when the Notice of Intent/invitation to the informational meeting letters are mailed or hand delivered to residents and legal decision-makers.

Purpose

The purpose of the initial informational meeting is for the facility to inform all residents and legal decision-makers or family members officially and verbally of the intent to relocate residents from the facility. The residents should leave the meeting knowing the reason they must relocate, the basics of the relocation planning process, and the contact information for the person at the facility to go to with questions.

Best practice is for the facility to have a representative available at the meeting to begin scheduling initial planning conferences with residents and legal representatives.

Participants and Roles

Participant	Role

Facility Representative	• Explain the reason(s) for requiring relocation of residents.
	• Articulate the facility role in the relocation process including:
	  ○ Relocation assistance
	  ○ Individual discharge planning (referrals, tours, visits, packing, moving)
	  ○ Reassurances of choice
	  ○ Facility representatives responsible for assisting residents throughout the duration of the relocation
	  ○ Next steps following the meeting

DHS Relocation Coordinator	• Give overview of the relocation process. • Describe role of DHS. • Describe role of the Resident Relocation Team.
Advocacy Organizations	• Give overview of the role of the advocates. • Give overview of rights. • Offer assistance to residents.
ADRCs	• Give overview of the role of the ADRC.

	• Offer assistance and resource materials.

Other participants may include representatives from the DQA, county, MCOs, and IRIS consultant agencies.

Initial Resident Relocation Team Meeting

Timing

This meeting should occur approximately one week after the informational meeting.

Purpose

The purpose of the initial relocation team meeting is for the facility and any involved care managers to provide the rest of the relocation team with an in-depth review of each resident's condition and needs, to share any known preferences for location, and to identify any obstacles or challenges to alternate placement. The first meeting most often takes considerably more time than subsequent meetings as the relocation team becomes familiar with each of the residents' needs and preferences.

Additional purposes of the initial resident relocation team meeting include:

- Conducting a review of each resident and getting clarification of all information provided or still needed
- Confirming that all resident clinical and financial information including updates on when applications for public funding is made available and that the information will be updated on a regular basis
- Confirming or clarifying each resident's decisional and legal status (and identifying any resident in need of a substitute decision-maker)
- Determining timelines/initial contact processes for ADRCs or other programs to initiate options counseling for residents
- Monitoring enrollment activity
- Confirming assignments of team members to ensure follow through

DID YOU KNOW?

The purpose of the initial relocation team meeting is to provide the rest of the relocation team with an in-depth review of each resident's condition and needs, and any known preferences for location as well as to identify any obstacles or challenges to alternate placement.

Participants

Key participants are the members of the State Relocation Team as described above and as established by the relocation coordinator.

The relocation coordinator prepares and provides a written agenda setting the date and time of the meeting and information for participating in person, by phone or other means; coordinates the communication protocols; and then maintains the relocation team contact list.

The facility will set the tone for a professional meeting by providing a space/room that is conducive to confidential discussion of protected resident health information.

Ongoing Relocation Meetings

Timing

This meeting should occur weekly or as otherwise determined by the relocation coordinator.

Purpose

The purpose of the ongoing relocation team meetings is for the facility and any care managers to continue providing the other team members with regular updates on the status of each residents' condition and developing a relocation plan including initial relocation; final discharge planning; conferences and/or other meetings; other orientation activities like referrals, assessments/screenings and/or outcomes; and tours and/or visits.

Additional purposes of the ongoing team meetings include:

- Receiving updates for any resident on any possible or actual change of condition from their initial status as first reported on the Resident Roster
- Identifying any potential barriers to a resident obtaining access to a desired living arrangement and planning strategies for resolution of obstacles
- Receiving updates on steps taken to assist each resident in identifying and exploring potential options for alternate living arrangements
- Monitoring progress towards and urging timely completion of desired referrals and required screenings and assessments

and monitoring changes in the resident's financial and/or legal status (including updates on contact information for decision-makers)
- Reviewing each resident's status regarding any involvement with the ADRC for options counseling and enrollment in MCOs, IRIS, and/or Medicaid fee-for-service (or other programs)
- Discussing the adequacy of care and services in proposed alternate settings
- Discussing exchanges of verbal and written information to promote continuity of care
- Assuring security of the resident's protected health information as it pertains to relocation activity
- Reviewing the details of each resident's discharge plan for adequate support once an alternate placement has been confirmed
- Reviewing and coordinating with resident-related entities such as insurance plans, their role in the resident relocation, and the status of the resident
- Monitoring that all appropriate written notifications have been made
- Receiving updates on the facility's operational status (for adequate staffing, provisions, and services) and any potential impact on relocation
- Discussing potential room/unit consolidation due to relocation
- Resolving any potential conflicts regarding an agency's scope of responsibility as it relates to individual residents

Participants

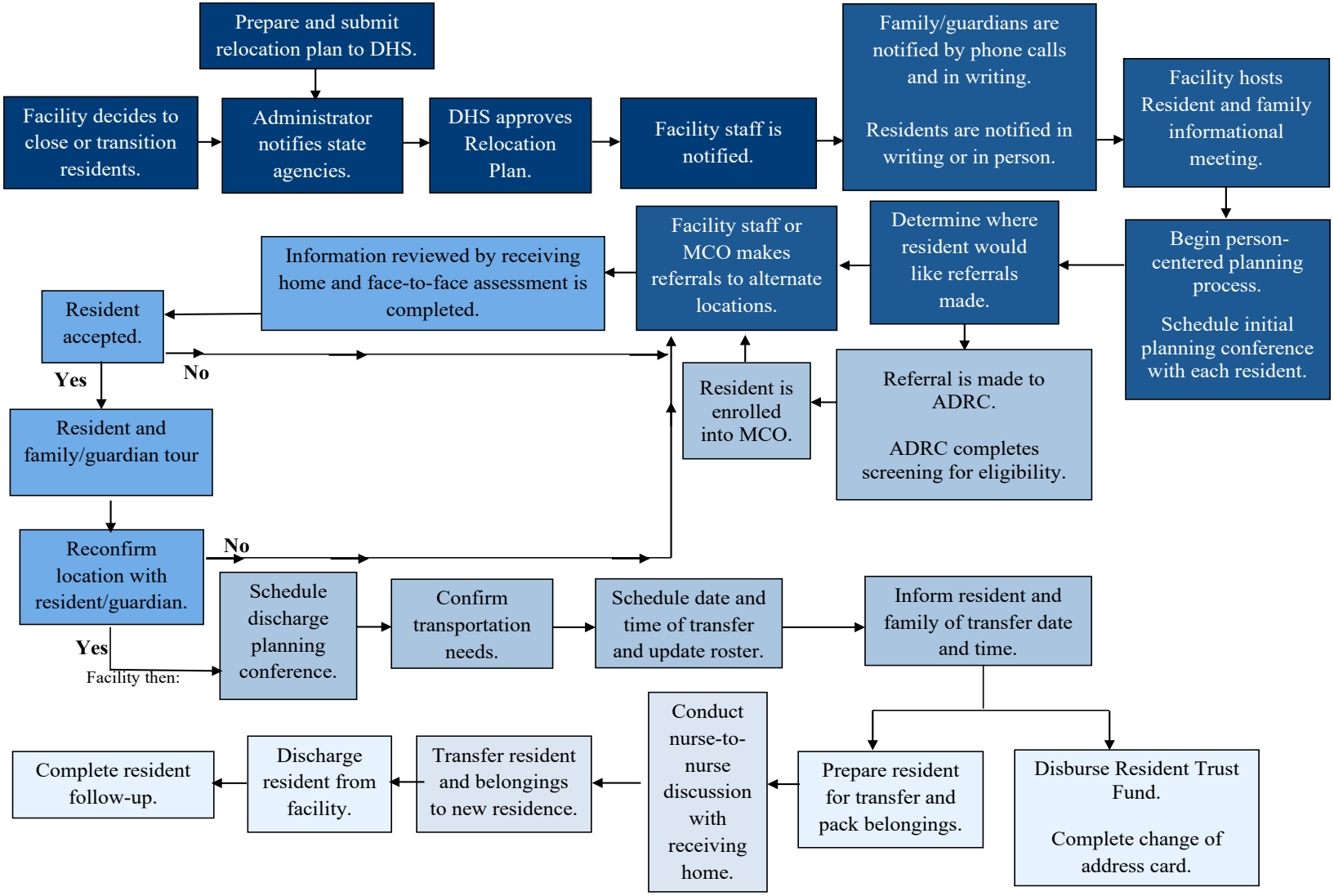
Key participants are the members of the State Relocation Team, as described above and as established by the relocation coordinator.

The relocation coordinator prepares and provides a written agenda setting the date and time of the meeting and information for participating in person, by phone, or other means; coordinates the communication protocols; and then maintains the relocation team contact list.

The facility will set the tone for a professional meeting by providing a space/room that is conducive to confidential discussion of protected resident health information.

Section VI: Resident-Centered Relocation Planning Overview

Flowchart for Resident Relocation Process



The Person-Centered Approach

DHS, under Wis. Stat. ch. 50, oversees the resident relocation process to ensure that residents are included in planning their relocation including choosing from among the available alternative placements that take proximity to the residents' relatives and friends into consideration.

DHS must see that Resident Relocation Plans and RSS/TT mitigation care plans are prepared and implemented to assure safe and orderly transfers and that the residents' health, safety, welfare, and rights are protected. The residents are to be provided with opportunities for at least three visits to potential alternative placements prior to relocation, except where medically contraindicated or where the need for immediate removal requires a reduction in the number of visits.

Facilities relocating residents under Wis. Stat. ch. 50 shall:

- Notify residents in writing of its intent to and rationale for relocating residents. The facility must also notify other involved persons and agencies including the resident's physician and any assigned care manager.
- Invite residents to participate in a meeting with state and local officials for the facility to formally and publicly announce the intent to relocate residents and to be informed of the kinds of relocation assistance to be provided.
- Notify and invite residents to participate in one or more individualized planning conferences to discuss the need for relocation, to assess the potential effect of the move on the resident, and to discuss available alternative placement options. At this meeting, an individualized relocation plan should be developed that describes what steps will be taken to assist the resident in exploring those options, including making referrals, exchanging information, and facilitating assessments and tours. The resident may involve anyone of their choosing at planning sessions or to seek the support of an advocate.
- Implement individualized resident relocation plans and keep residents informed and involved in the process.
- Provide all required notices. Refer to the description of notices below.

DID YOU KNOW?

The residents are to be provided with opportunities for at least three visits to potential alternative placements prior to relocation, except where medically contraindicated or where the need for immediate removal requires a reduction in the number of visits.

- Support residents on tours and visits and make necessary arrangements for transportation.
- Formally notify each resident in writing of the discharge date and location of discharge once a decision is made and provide rights to question or appeal any part of the relocation plan.
- Notify and invite residents and others to participate in a final individualized planning conference to work out the details of the move and to ask any remaining questions to feel fully prepared to relocate.
- Provide adequate assistance and support with physically relocating and moving belongings.
- Provide follow-up to check on resident adjustment and to address any subsequent concerns in the new setting.

Relocation/Discharge Planning Conference

Every resident has a right to receive, and facilities are required to provide, sufficient preparation and orientation to ensure safe and orderly discharge. This may require more than one planning session to meet the regulatory requirements for certain transfer and discharge activities to occur. The resident has a right to be informed of the available options involved in choosing an alternate living arrangement as well as to participate in the planning of the transfer. The need for relocation should be reviewed and the effect of the move on the resident should be assessed. This session should result in the development and implementation of an individualized relocation plan as well as a care plan to mitigate any possible evidence of resident RSS associated with the transfer.

This session should result in the development and implementation of an individualized relocation plan as well as a care plan to mitigate any possible evidence of resident RSS associated with the transfer.

The facility is expected to provide counseling regarding the impending transfer as well as an opportunity for the resident to make one to three visits to a potential alternate placement. The facility should arrange transportation as needed and assist in arranging an opportunity for the resident to meet with that facility's admission staff. The discharging facility should then follow up with both the resident and the potential alternate living arrangement on the results of the visit.

After a decision has been made and both the resident and potential alternate placement facility have agreed upon the resident's transfer, a planning session should be scheduled to discuss the final details of the move including the kinds of assistance to be provided in moving the resident and their belongings, funds, and provisions for medications and treatments.

A post discharge plan of care that identifies instructions for continued care and assists the resident with adjusting to their new living arrangement must be developed with the participation of the resident and their family and/or legal representative. A final summary of the resident's status must be made available at the time of discharge for release, upon consent, to authorized persons and agencies. A final statement that accounts for all funds and property held by the facility must be prepared upon the resident's discharge.

Notice Before Discharge

Every resident has a right to receive, and facilities are required to provide, reasonable advanced written notice of any planned discharge. This notice is to be made to the resident, any authorized decision-maker, a known family member (unless the resident requests that the family not be notified), legal counsel, and the resident's physician. The notice must be made in writing and in a language and manner that is understood by the resident and others.

The written notice must be made at least 30 days before the resident is to be discharged, unless the continued presence of the resident at the facility endangers the health, safety, or welfare of the resident or others, the immediate transfer is required by the resident's urgent medical need, or the resident's health improves sufficiently to allow a more immediate transfer. The resident may be discharged at their request or upon the informed consent of the resident's legal decision-maker. Should the resident elect to move sooner, or if they have not resided at the facility for 30 days (or for any of the reasons stated above), notice should be made as soon as practicable before the discharge. The facility is required to provide sufficient preparation and orientation to the resident to ensure safe and orderly discharge and is required to offer

DID YOU KNOW?

Should the resident elect to move sooner, or if they have not resided at the facility for 30 days (or for any of the reasons stated), notice should be made as soon as practicable before the discharge.

relocation assistance. Certain requirements establish timelines for notification of a discharge planning conference as well.

The written notice must state the reason for discharge. State and federal rules significantly restrict the circumstances under which a facility can involuntarily discharge a resident. A relocating facility may discharge the resident as the facility will cease to operate or as otherwise allowable by law. The notice must explain the need for the relocation.

The written notice must state the location to which the resident is to be discharged or relocated. The resident may not be involuntarily discharged unless the resident has chosen an alternate living arrangement and the entity has accepted the resident and the alternate placement is arranged. A facility to which the resident is to be discharged must have accepted the resident and in advance of the discharge or relocation.

The written notice must state the effective date of the discharge or relocation. The resident may not be involuntarily discharged or relocated unless alternate living arrangements have been secured and the resident has been provided with sufficient orientation and adequate preparation.

The written notice must inform the resident of the right to appeal the discharge plan. Please note that while the resident may appeal the discharge plan, they may not appeal the facility's decision to close. The notice must explain how to appeal the action. No resident, having appropriately filed a written appeal, may be discharged until after the DQA has completed its review and has notified both the resident and the facility of its decision.

The written notice must provide the resident with contact information (name, address, and phone number) for the nearest office of the DQA and for either the ombudsman program (Board on Aging and Long-Term Care) for residents over 60 years or the protection and advocacy organization (Disability Rights Wisconsin) for residents under 60 years of age.

Refer to Section IX: Appendices for sample notices.

Section VII: Relocation Stress Syndrome

Identification of Relocation Stress Syndrome/Transfer Trauma

Purpose

DHS must see that Resident Relocation Plans and TT mitigation care plans are prepared and implemented to assure safe and orderly transfers, and that the residents' health, safety, welfare, and rights are protected while minimizing RSS/TT.

It is recommended that the tools provided in this section be provided to all receiving facilities and community service providers as part of the transfer documentation.

Definition

Physiologic and/or psychosocial disturbances that may result for a resident during the process of relocation from one environment to another.

Symptoms

Symptoms may include any of the following[1]:

- Depression
- Anger
- Loss of trust
- Insecurity
- Decreased vigor
- Perceived loss of control
- Change in eating habits
- Delirium
- Medical visits
- Morbidity
- Anxiety
- Fearfulness
- Excess need of reassurance
- Withdrawal
- Thought intrusion
- Sleep disturbance
- Increased falls
- Loss of immunocompetence

DID YOU KNOW?

Relocation Stress Syndrome: Physiologic and/or psychosocial disturbances that may result for a resident during the process of relocation from one environment to another.

- Weight loss
- Mortality
- Confusion

1. Hirdes J et al. The MDS-CHESS Scale: A new measure to predict mortality in institutionalized older people. *Journal American Geriatric Society* 51, 96–100

Strategies for Mitigation of Relocation Stress

The strategies for mitigating RSS/TT include the facility:

- Notifying the resident and interested parties and keeping informed throughout the transition. Facilities should provide face-to-face meetings for resident and family/guardian to provide information and offer reassurances throughout the process. Questions can then be addressed in a timely manner. The facility may provide written notices and other information.
- Educating residents, families/guardians, and staff regarding the relocation process so that everyone is aware of the process and who they should contact with questions and concerns.
- Reviewing Resident Rights and grievance and appeal procedures with residents and families or legal decision-makers.
- Reminding all staff to immediately respond to and/or seek further assistance for residents and families/legal decision-makers when there are concerns to be addressed.
- Assessing and implementing a temporary care plan to ensure the process is resident focused and that the residents' needs are being met throughout the process.
- Holding an initial planning conference with each resident, legal decision-maker, case manager, and/or resource center representatives as indicated to develop the care plan and individualized relocation plan.
- Assisting the resident in exploring options for alternate living arrangements with an individualized relocation plan, which describes which steps will be taken including referrals, assessment process, and exchanges of information. A plan should be developed in collaboration with any involved case management organization.
- Involving each resident/family/legal decision-maker in determining the best ways to prepare the resident to relocate.

This should include tours and visits. Familiar staff should accompany residents on tours and visits to support and to assist with any care needs.

- Convening a discharge planning meeting with each resident, their family and legal decision-maker, care manager (as appropriate), and an advocate (as invited) when an alternate living situation is confirmed. Involve the subsequent care and service providers in this meeting to develop a discharge plan that details the final steps to be taken to safely relocate and support the residents during transfer.
- Providing adequate support and assistance in packing and moving. Plan for familiar persons to remain to help the resident settle into the new environment.
- Following up with the resident via phone or face-to-face visit to ensure the success of the relocation and to work out any issues that may occur in the new setting.

Mitigation of Relocation Stress

Tours and Visits

Overview

Each resident has a right to be sufficiently prepared for relocation, and the facility must assure a safe and orderly transfer. The resident has the right to make repeated visits to tour and then become familiar with the proposed alternate living arrangement unless waived by the resident or determined to be medically contraindicated. Best practices include providing opportunities to first tour the proposed location, then return for a meal and/or activity on a second visit, and even stay overnight on a third occasion.

The resident has the right to make repeated visits to tour and then become familiar with the proposed alternate living arrangement.

Best Practices

While the resident or interested party is free to visit any location, the relocating facility should work with any involved MCO to help determine available options and should then seek a preliminary confirmation from the home of an ability to admit and serve the individual before promoting a visit to help avoid any subsequent disappointment at not being able to move to a preferred, but unavailable setting.

The relocating facility should offer and provide familiar staff or direct care staff to accompany and support the individual, especially when direct assistance with personal care may be required. It should provide or arrange for transportation and make whatever other arrangements may be necessary to avoid inconveniencing or discouraging the resident or their informal supports. No cost should fall to the resident or other interested party when either visiting or moving.

If a resident declines or waives the right to a tour, the facility should attempt to determine the rationale for the refusal and to mitigate any extenuating circumstances such that the resident may feel more encouraged to visit. Likewise, in a case where a resident's properly authorized substitute decision-maker waives the right, the facility should attempt to educate the person as to why the visit may be beneficial and hold the agent or guardian to a similar standard for rights denial. The facility and other interested parties must present the option and then defer the decision to the resident if they indicate any desire to tour unless doing so presents a real threat to the individual's health, safety, or welfare.

If a resident's care team determines that touring is medically contraindicated, the facility should consult with the individual's physician to determine any possible ways to mitigate the threat and then develop and implement a safe plan and document the rationale for waiving the right in the resident's medical record.

Individuals who present with a cognitive condition that might cause the individual to be unaware, confused, or later forget the visit is not sufficient grounds to determine the tour to be medically contraindicated unless the probability of harm can be supported and documented.

DID YOU KNOW?

The relocating facility should offer and provide familiar staff or direct care staff to accompany and support the individual especially when direct assistance with personal care may be required.

Best Practices for Supporting Residents When No Tour Will Occur

In a situation where the resident either declines the option or the care team determines the visit to be medically contraindicated, the facility must develop another strategy for preparing the resident for transfer, such as:

- Looking at pictures or marketing materials.
- Taking a virtual or online tour.
- Taking a real-time tour using technology with the resident watching as a loved one tours the facility.
- Meeting with potential new caregivers to become familiar with them and beginning to educate the new provider in the needs, preferences, routines, and habits of the resident in a more familiar setting.

If a tour or visit is determined to be medically contraindicated, the facility must address the circumstances and develop a plan to mitigate the threat for when the resident is actually transferring to the new facility.

Likewise, on the day of the actual move, the relocating facility should offer and plan to directly support the resident with transportation and whatever direct assistance may be required while in transit and upon arrival in the new setting. Familiar staff might be helpful in making for a smoother transition by assisting the resident to unpack and settle in. Staff may make themselves available to new staff to possibly answer any remaining questions about the resident's needs and preferences.

The relocating facility must assure that the resident has been safely transported to and admitted by the receiving setting and should furnish the new provider with a name and phone number in case additional information about the resident is needed later.

Staff Relocation Stress in Facility Closures

When the announcement is made to the affected staff, it may represent the "worst-case scenario" for the employee. Staff may have suspected the facility would be closing, making changes, or it may be a total shock to some or all of the employees. The facility needs to be aware of the effect the announcement will have on staff well-being and the potential impact on staff job performance.

Staff Reaction

The staff may experience similar effects of RSS. They have not decided to end their employment. They may be outstanding employees who have always produced a quality work product. Through no fault of their own they are losing their employment, their financial livelihood, and an important part of their identity. They will be involuntarily separated from residents they care about, friends, and co-workers.

Ultimately, there is nothing the staff person can do to reverse the facility closure decision. They will come to understand they have no control over the ultimate outcome. For at least some time, the staff will realize they have lost control over a major component of their life.

This is a difficult time in the staff person's life. They will be expected to continue to perform their job functions in a professional manner. The direct care staff will be the key persons expected and needed to assist the residents in coping with their own shock and grief. They will have to assist the residents in preparing for relocation to a new living environment, and the time to actively grieve their loss will be very limited.

The residents are being forced to leave their familiar surroundings, staff, other residents, friends, and a facility they may consider to be home. The staff is experiencing a parallel scenario to the residents.

Facility Interventions for Staff

In advance of the announcement, the facility needs to have a strategy to address the stress experienced by staff.

Interventions to address this stress may include the following:

- Allowing the staff to verbalize their initial reactions
- Assisting staff with understanding the normalcy of the emotions they are experiencing
- Letting them know the facility will not be closing immediately but will be open until the last resident is relocated
- If possible, offering a financial package to help staff determine if they will stay and assist in the relocation of the residents
- Considering facilitating the staff to meet as a group to share their feelings on the closure and what it means to them

- Letting staff know the facility will be supportive as they seek future employment
- Providing direction to available job services
- Letting other providers know the facility is closing and staff will be seeking new employment
- Reassuring staff by initiating action to provide job references
- Assisting staff with resume writing or providing a class on writing resumes
- Facilitating information sharing that is helpful in the job search and developing an area dedicated to resources for new employment opportunities
- Keeping staff in the informational loop during the closure process (Staff needs to be aware of any potential effects of attrition of staff. Staff may voluntarily leave as they find new jobs, or they may face lay off as residents leave and they are no longer needed in the same numbers.)
- Assuring staff that they will be given notice as soon as it is evident that their personal employment will be ending on a certain date
- Having procedures to discuss notifying staff about potential layoffs openly and before the layoffs actually begin

Staff In-Service

Staff need to quickly receive in-service on RSS and how it directly affects residents and their families. Just as staff are anxious about what the future holds for them, many residents will also be very anxious. Interventions need to be discussed with staff to help mitigate the relocation stress residents are experiencing. These interventions should be individualized to residents and care planned. Direct care staff have a major role in identifying resident RSS and conducting the care plan interventions to aid in its mitigation. In understanding the effects of RSS on residents, staff will gain a better understanding of their own relocation stress.

Staff Role in Resident Relocation

Staff are essential to the implementation of a successful relocation process for each resident. Each staff member with resident contact should be asked to provide care plan information that they consider essential for a receiving facility or service provider to have for the resident to successfully relocate to a new facility or other community setting. Staff members know resident likes and dislikes; often housekeeping and maintenance staff are also well versed in residents' likes and dislikes as residents may relate to them on a daily basis.

Each staff member with resident contact should be asked to provide care plan information that they consider essential for a receiving facility or service provider to have for the resident to successfully relocate to a new facility or other community setting.

Staff should accompany residents on tours of new facilities/settings as a resource in evaluating the appropriateness of the setting and as a support for the resident. This aspect can be incorporated into daily activities for the residents.

Staff should accompany residents to their new facilities/settings whenever possible. They can assist the resident in settling in. Staff that know the resident's individual preferences can assist the new facility/service provider in learning this critical information.

Staff may be aided in coping with their own RSS if they are assured that the residents are achieving an appropriate placement.

Summary

Staff may experience ongoing grieving over the facility closure and will need to be supported. Resources need to be identified and provided on an ongoing basis. Direct care staff are critical in providing residents with support for the relocation stress they are experiencing.

Experienced staff need to be retained to provide quality care to residents. This is one of the major challenges facing the administration of a closing facility. Strategies for retention must be planned, initiated, and evaluated throughout the closure process to ensure RSS for both residents and staff is mitigated to the extent possible.

References

- "Relocation Best Practices for Discharging and Receiving Facilities," Resident Relocation Planning and Procedure Manual, Department of Health Services, July 2005
- Winona State University, Master's Program in Nursing, Prinsen S. and Henley J., Nursing Home Closure, Chapter V, "Effects on Staff," 2005

Best Practice for Receiving Facility

For receiving facilities/entities, the goal is to focus on the relocated resident and their needs and wishes in order to mitigate or minimize RSS/TT after relocation. The following actions will assist the resident in adjusting to their new living setting/home:

- Welcome the resident while touring the receiving facility before the actual day of the move.
- Arrange for a caregiver to visit the resident in the relocating facility to ease the resident's transition to their new home by establishing familiarity.
- Participate in a discharge planning conference at the relocating facility to give input and become aware of the details of the resident's transfer.
- Designate a primary contact person at the receiving facility for the resident/family/legal representative to keep in communication with throughout the relocation process. Provide contact information for key staff.
- Assist the resident with unpacking and organizing belongings with the resident's input. Review the resident's inventory of personal belongings from the relocating facility and verify the presence of all belongings and funds. Orient the resident to the new facility and to the usual daily routines.
- Introduce the new resident to the other residents, volunteers, staff, and families when the resident is willing and able. Invite and encourage participation in meals and activities.
- Assure that staff review transfer information (physician's orders, medical history, social history, etc.) and complete admission assessments. Include the resident/family/legal representative's input in the assessment process. Contact the relocating facility to clarify transfer information, as needed.

- Be familiar with resident information regarding likes, dislikes, preferred daily routines, etc., and ensure the information becomes part of the direct caregivers' care plan.
- Establish routines for the resident with input from the resident and their family/ guardian and with information shared from the relocating facility.
- Assign a consistent qualified staff to assist the resident with transition to their new environment and to assess the resident frequently to monitor for signs of RSS/TT so that necessary interventions can be implemented. Allow the resident time to adjust.
- Know that a resident who is relocating may be experiencing emotional and physical symptoms related to RSS/TT. Address and document the resident's reactions and concerns.

Staff should be alert for and put interventions in place to address safety risks such as weight loss, falls, anxiety, and confusion that could result from residents being in an unfamiliar environment.

Section VIII: Statutory and Administrative Code Requirements

Statutes and Codes

www.dhs.wisconsin.gov/regulations/health-residential.htm

The link above will lead to the DHS Regulation of Health and Residential Care Providers webpage with links to Wis. Stat. ch. 50 and the Code of Federal Regulations website:

- For Wisconsin Statutes:
  - Click the appropriate provider type.
  - Click the Rules and Regulations tab on the left side of the screen, then a link to the state administrative code will be displayed.
- For federal regulations, click electronic Code of Federal Regulations link under Federal Regulations.

Statutory Reference Chapter 50

https://docs.legis.wisconsin.gov/statutes/statutes/50.pdf

Wisconsin Statutory Requirements

Statutory Background

Applicable statutes—Chapter 50 is all-inclusive when referring to "facilities" involved in resident relocations. Facilities refer to nursing homes, facilities serving people with developmental disabilities/ICFs-IIDs, and CBRFs.

DHS has statutory authority under Wis. Stat. § 50.03(14)(a) to provide, direct, or arrange for resident relocation planning, placement, and implementation services to minimize the trauma associated with the relocation of residents and ensure the orderly relocation of residents. This gives DHS the authority to monitor facility resident relocations and to provide assistance when necessary. The implementation of the Resident Relocation Plan is monitored by the State Relocation Team. Updates and interventions are done as needed. The DQA will provide regulatory oversight as needed.

Wis. Stat. § 50.03(5m)(a)1–6 authorizes DHS to remove residents from any facility licensed under this chapter when any of the following conditions exist:

- The facility is operating without a license.
- DHS has suspended or revoked the existing license of the facility.
- DHS has initiated revocation procedures under Wis. Stat. § 50.03(5) and has determined that the lives, health, safety, or welfare of the residents cannot be adequately assured pending a full hearing on license revocation.
- The facility has requested the aid of DHS in the relocation of the resident, and DHS finds that the resident consents to relocate, the move is made for valid medical reasons, or the move is made for the welfare of the resident or other residents.
- The facility is closing, intends to close, or is changing its type or level of services or means of reimbursement accepted and will relocate at least five residents or 5% of the residents, whichever is greater.
- DHS determines that an emergency exists that requires immediate relocation of the resident. An emergency is a situation, physical condition, or one or more practices, methods, or operations that presents imminent danger of death or serious physical or mental harm to a resident of a facility.

During any relocation activity, the facility is required to continue to provide care and treatment in compliance with its licensure mandates in Wis. Stat. ch. 50; Wis. Admin. Code chs. DHS 83, 132, and 134; Medicare and Medicaid certification requirements and any other applicable federal or state regulatory requirements. Facilities relocating residents because of regulatory enforcement action shall nonetheless be expected to provide services according to applicable state and federal regulatory requirements.

Federal Regulations and Wisconsin Administrative Codes

Refer to the provided links for the regulations in their entirety at the beginning of this section.

Skilled Nursing Facilities and Nursing Homes

Wis. Admin. Code ch. DHS 132—Nursing Home

A facility licensed under Wis. Admin. Code ch. DHS 132 must comply with the following requirements:

1. **DHS 132.54—Transfer within the facility.** Prior to any transfer of a resident between rooms or beds within a facility, the resident or guardian, if any, and any other person designated by the resident shall be given reasonable notice and an explanation of the reasons for transfer. Transfer of a resident between rooms or beds within a facility may be made only for medical reasons or for the resident's welfare or the welfare of other residents or as permitted under s. DHS 132.31(1)(p)1.
2. **DHS 132.53(3)—Procedures**.
   (a) Notice. The facility shall provide a resident, the resident's physician and, if known, an immediate family member or legal counsel, guardian, relative or other responsible person at least 30 days' notice of transfer or discharge under sub. (2)(a)2. to 10, and the reasons for the transfer or discharge, unless the continued presence of the resident endangers the health, safety or welfare of the resident or other residents. The notice shall also contain the name, address and telephone number of the board on aging and long-term care. For a resident with developmental disability or mental illness, the notice shall contain the mailing address and telephone number of the protection and advocacy agency designated under s. 51.62(2)(a), Stats. (Disability Rights Wisconsin)
   (b) Planning Conference.
      1. Unless circumstances posing a danger to the health, safety or welfare of a resident require otherwise, at least 7 days before the planning conference required by sub. 2., the resident, guardian, if any, any appropriate county agency, and others designated by the resident, including the resident's physician, shall be given a notice containing the time and place of the conference, a statement informing the resident that any persons of the resident's choice may attend the conference, and the procedure for submitting a complaint to the department.

2. Unless the resident is receiving respite care or unless precluded by circumstances posing a danger to the health, safety, or welfare of a resident, prior to any involuntary transfer or discharge under sub. (2) (a) 2. to 10., a planning conference shall be held at least 14 days before transfer or discharge with the resident, guardian, if any, any appropriate county agency, and others designated by the resident, including the resident's physician, to review the need for relocation, assess the effect of relocation on the resident, discuss alternative placements and develop a relocation plan which includes at least those activities listed in subd. 3.
3. Transfer and discharge activities shall include:
    a. Counseling regarding the impending transfer or discharge;
    b. The opportunity for the resident to make at least one visit to the potential alternative placement, if any, including a meeting with that facility's admissions staff, unless medically contraindicated or waived by the resident;
    c. Assistance in moving the resident and the resident's belongings and funds to the new facility or quarters; and
    d. Provisions for needed medications and treatments during relocation.
4. A resident who is transferred or discharged at the resident's request shall be advised of the assistance required by subd. 3. and shall be provided with that assistance upon request.

(c) Records. Upon transfer or discharge of a resident, the documents required by s. DHS 132.45(5)(L) and (6)(h) shall be prepared and provided to the facility admitting the resident, along with any other information about the resident needed by the admitting facility.

Code of Federal Regulations: 42 C.F.R. 483.15(c)

Federally certified nursing home facilities must comply with the following federal regulations in addition to state requirements for relocation planning:

1. **42 C.F.R. 483.15(c)(3)–(7) requires:**

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

(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.

(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and

(iii) Include in the notice the items described in paragraph (c)(5) of this section.

2. **42 C.F.R. 483.21(c)(2) requires:**

(2) Discharge summary. When the facility anticipates discharge a resident must have a discharge summary that includes, but is not limited to, the following:

(i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.

(ii) A final summary of the resident's status to include items in paragraph (b)(1) of § 483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.

(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).

(iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.

Community Based Residential Facilities

Wis. Admin. Code ch. DHS 83

A facility licensed under Wis. Admin. Code ch. DHS 83 must comply with the following requirements:

1. **DHS 83.11 Facility closing.**
   (1) Any CBRF that intends to close shall notify the department in writing at least 30 days before closing and comply with the requirements under s. 50.03(5m), Stats., and s. DHS 83.31.
   (2) If a CBRF is closing, intends to close, or changes its type or level of service or means of reimbursement and will relocate 5 residents or 5% of the CBRF's residents, whichever is greater, the CBRF shall follow the procedures under s. 50.03(14), Stats.
   Note: The CBRF needs to comply with the content of this manual if it meets the criteria in (2).
   (3) The CBRF shall surrender the license to the department when the CBRF closes.
2. **DHS 83.31(7) Information Provided at Time of Transfer or Discharge.** At the time of a resident's transfer or discharge, the CBRF shall inform the resident or the resident's legal representative and the resident's new place of residence that all of the following information is available in writing upon request:
   (a) *Facility information*. The name and address of the CBRF, the dates of admission, and discharge or transfer, and the name and address of a person to contact for additional information.
   (b) *Medical providers*. Names and addresses of the resident's physician, dentist and other medical care providers.
   (c) *Emergency contacts*. Names and addresses of the resident's relatives, or legal representative to contact in case of emergency.
   (d) *Other contacts*. Names and addresses of the resident's significant social or community contacts.
   (e) *Assessment and individual service plan*. The resident's assessment and individual service plan, or a summary of each.
   (f) *Medical needs*. The resident's current medications and dietary, nursing, physical and mental health needs, if not included in the assessment or individual service plan.

(g) *Reason for discharge or transfer*. The reason for the resident's discharge or transfer.

3. **DHS 83.31(4) Discharge or Transfer Initiated by CBRF.**

(a) *Notice and discharge requirements*.

1. Before a CBRF involuntarily discharges a resident, the licensee shall give the resident or legal representative a 30 day written advance notice. The notice shall explain to the resident or legal representative the need for and possible alternatives to the discharge. Termination of placement initiated by a government correctional agency does not constitute a discharge under this section.

(c) *Notice requirements*. Every notice of involuntary discharge shall be in writing to the resident or resident's legal representative and shall include all of the following:

1. A statement setting forth the reason and justification for discharge listed under par. (b).
2. A statement that the resident or the resident's legal representative may ask the department to review the involuntary discharge by sending a written request within 10 days of receipt of the discharge statement to the department's regional office with a copy to the CBRF. The notice shall state that the request must provide an explanation why the discharge should not take place.
3. The name, address and telephone number of the department's regional office director.
4. The name, address and telephone number of the regional office of the board on aging and long-term care's ombudsman program. For residents with developmental disability or mental illness, the notice shall include the name, address and telephone number of the protection and advocacy agency designated under s.51.62(2)(a), Stats.

(d) *Department review of discharge*.

1. A resident may request department review of an involuntary discharge within 10 days of receipt of such notice. If a timely request is sent to the department, the CBRF may not proceed with an involuntary discharge until the department has completed its review and notified the resident or the resident's legal

representative and the CBRF of the department's decision.

2. Within 7 days after receiving the copy of the letter requesting the review, the CBRF may provide to the department's regional office, additional information justifying the discharge.
3. The department shall complete its review within 10 days after the CBRF submits additional information under subd. 2., if any, and will notify in writing the resident or the resident's legal representative and the CBRF of the department's decision.

Facilities Serving People With Developmental Disabilities and Intermediate Care Facilities for Individuals With Intellectual Disabilities

Wis. Admin. Code ch. DHS 134

A facility licensed under Wis. Admin. Code ch. DHS 134 must comply with the following requirements:

DHS 134.53(4) Permanent Involuntary Removal

(b) *Notice*. The facility shall provide the resident, the resident's family or guardian or other responsible person, the appropriate county department designated under s. 46.23, 51.42 or 51.437, Stats., and, if appropriate, the resident's physician, with at least 30 days notice before making a permanent removal under sub. (2)(b), except under sub (2)(b)5. or if the continued presence of the resident endangers his or her health, safety or welfare or that of other residents.

(c) *Removal procedures*.

1. Unless circumstances posing a danger to the health, safety or welfare of a resident require otherwise, at least 7 days before the planning conference required by subd. 2., the resident, guardian, if any, the appropriate county department designated under s. 46.23, 51.42 or 51.437, Stats., and any person designated by the resident, including the resident's physician, shall be given a notice containing the time and place of the conference, a statement informing the resident that any persons of the resident's choice may attend the conference and the procedure for

submitting a complaint to the department about the prospective removal.

2. Unless the resident is receiving respite care or unless precluded by circumstances posing a danger to the health, safety or welfare of a resident, prior to any permanent involuntary removal under sub. (2)(b), a planning conference shall be held at least 14 days before removal with the resident, the resident's guardian, if any, any appropriate county agency and any persons designated by the resident, including the resident's physician or the facility QDIP, to review the need for relocation, assess the effect of relocation on the resident, discuss alternative placements and develop a relocation plan which includes at least those activities listed in subd. 3.
3. Removal activities shall include:
    a. Counseling the resident about the impending removal;
    b. Making arrangements for the resident to make at least one visit to the potential alternative placement facility and to meet with that facility's admissions staff, unless this is medically contraindicated or the resident chooses not to make the visit;
    c. Providing assistance in moving the resident and the resident's belongings and funds to the new facility or quarters; and
    d. Making sure that the resident receives needed medications and treatments during relocation.

(d) *Transfer and discharge records.* Upon removal of a resident, the documents required by s. DHS 134.47(4)(k) shall be prepared and provided to the facility admitting the resident, along with any other information about the resident needed by the admitting facility. When a resident is permanently released, the facility shall prepare and place in the resident's record a summary of habilitative, rehabilitative, medical, emotional, social and cognitive findings and progress and plans for care.

Code of Federal Regulations: 42 C.F.R. 483.440

Federally certified ICFs-IIDs must comply with the following federal regulations in addition to state requirements for relocation planning.

42 C.F.R. 483.440(b)(4)(i)–(b)(5)(ii) states the following:

(4) If a client is to be either transferred or discharged, the facility must—
  (i) Have documentation in the client's record that the client was transferred or discharged for good cause; and
  (ii) Provide a reasonable time to prepare the client and his or her parents or guardian for the transfer or discharge (except in emergencies).

(5) At the time of the discharge, the facility must—
  (i) Develop a final summary of the client's developmental, behavioral, social, health and nutritional status and, with the consent of the client, parents (if the client is a minor) or legal guardian, provide a copy to authorized persons and agencies; and
  (ii) Provide a post-discharge plan of care that will assist the client to adjust to the new living environment.

Section IX: Appendices

Appendix A—Contact Information

- Aging and Disability Resource Centers (ADRCs) https://www.dhs.wisconsin.gov/adrc/consumer/index.htm
- Board on Aging and Long-Term Care (BOALTC) https://longtermcare.wi.gov/
- Bureau of Quality and Oversight (BQO) DHSDMSLTC@dhs.wisconsin.gov or 608-267-7286
- BQO Relocation Coordinator dhsresidentrelocations@dhs.wisconsin.gov or 608-267-7286
- Bureau of Assisted Living (BAL) https://www.dhs.wisconsin.gov/dqa/bal-regionalmap.htm
- Bureau of Nursing Home Resident Care (BNHRC) https://www.dhs.wisconsin.gov/dqa/bnhrc-regionalmap.htm
- Disability Rights Wisconsin (DRW) https://www.disabilityrightswi.org/
- Division of Quality Assurance (DQA) Regulation of Health and Residential Care Providers https://www.dhs.wisconsin.gov/regulations/health-residential.htm
- Family Care Managed Care Organizations (MCOs) https://www.dhs.wisconsin.gov/familycare/mcocontacts.pdf

Templates and Samples

The following appendices and optional sample forms are linked separately as templates that facilities can easily modify and use. Download an editable version of the templates at www.dhs.wisconsin.gov/publications/p01440a.docx.

Appendix B—Sample Notification Letter/Invitation to Informational Meeting

Click or tap to enter a date.

Click or tap here to enter text.

Click or tap here to enter text.

Click or tap here to enter text.

Click or tap here to enter text.:

Due to , Click or tap here to enter text. has made the very difficult decision to Choose an item.. As required per state law, Click or tap here to enter text. submitted a Resident Relocation Plan to the State of Wisconsin on Click or tap to enter a date.. We anticipate that we can successfully help each individual relocate to an appropriate living arrangement. Please be assured that the facility will remain open until each resident is properly relocated, and that we will be working very closely with you throughout the planning of your move.

Please join us for an informational meeting at Click or tap here to enter text., Click or tap here to enter text. on Click or tap to enter a date., at Click or tap to enter a date.. At the meeting we will share all of the information you will want to know about this process, discuss the support that will be provided to you, and give you opportunities to ask questions.

During this transition period you can expect the following from us:

- A planning conference will be scheduled, at which time an individual relocation plan will be developed and will be monitored by the State Resident Relocation Team.
- A comprehensive assessment will be completed.
- You will have the opportunity to meet with representatives from various agencies who can provide information on current options that may be available to you for placement alternatives and will assist in your exercise of choice.
- Your physician will be consulted to assure your well-being and health.
- You will be given the opportunity to meet with representatives from other facilities including nursing homes, community-based residential facilities, adult family homes, other assisted living providers, and community settings that you are interested in.
- You will have the opportunity to visit proposed settings in-person or virtually.

We have designated Click or tap here to enter text. to be the facility Relocation Coordinator. They will oversee the relocation process and be available to answer any questions that you might have. The phone number is Click or tap here to enter text..

If you do not understand your rights regarding discharge, please contact Click or tap here to enter text. to assist you. They will help you exercise those rights. Your Ombudsman has also received a copy of this letter and can also help you through this process. Your Ombudsman is available to be present at your discharge planning conference if you desire. Below you will find contact information for the Ombudsman (for people over age 60) and Disability Rights Wisconsin (for people between ages 18-59).

Click or tap here to enter text., Long-Term Care Ombudsman

State of Wisconsin

Board on Aging and Long-Term Care

Click or tap here to enter text.

Click or tap here to enter text.

Phone: Click or tap here to enter text.

Disability Rights Wisconsin

Click or tap here to enter text.

Click or tap here to enter text.

Phone: Click or tap here to enter text.

Sincerely,

Click or tap here to enter text., Click or tap here to enter text.

Appendix C—Sample Notice to Physicians

Click or tap to enter a date.

Click or tap here to enter text.

Click or tap here to enter text.

Click or tap here to enter text.

Click or tap here to enter text. :

We are writing to inform you that due to Click or tap here to enter text., Click or tap here to enter text. has decided to Choose an item.. Click or tap here to enter text. plans to assist residents with relocation within Choose an item. days from the date of the approval of the Resident Relocation Plan. Please be assured that our staff will be working with all of our residents, including your patients as identified below, to help identify an appropriate alternate living arrangement and to make sure each resident's move is as safe and pleasant as possible:

- Click or tap here to enter text.
- Click or tap here to enter text.
- Click or tap here to enter text.

We ask for your assistance to help assure each resident's continuity of care.

During the next few weeks, we will be consulting with you regarding each of your patients at Click or tap here to enter text. and the effects of the proposed relocation on their health. In the meantime, if you have any concerns or questions about our relocation plan, please contact me at Click or tap here to enter text..

Again, it is our goal to make this transition as pleasant as possible for each resident. We appreciate your assistance as we work toward this goal.

Sincerely,

Click or tap here to enter text., Administrator

Appendix D—Sample Notice to Community Stakeholders/County/Aging and Disability Resource Center/Managed Care Organizations

Click or tap here to enter text.

Click or tap here to enter text.

Click or tap here to enter text.

Click or tap here to enter text.

Click or tap here to enter text.:

Due to Click or tap here to enter text., Click or tap here to enter text. is formally notifying you of our intent to Choose an item. Click or tap here to enter text. We have submitted a Resident Relocation Plan to the Wisconsin Department of Health Services for their review and received approval on Click or tap to enter a date.. We anticipate relocations to be complete within Choose an item. days of the date of approval of the relocation plan. We will be working with representatives from your organization to develop and implement individual relocation plans for our residents, as appropriate.

We have designated Click or tap here to enter text. as the Relocation Coordinator for the facility. Choose an item. will serve as your central point of contact and can be reached at Click or tap here to enter text..

It is our goal to make this transition as pleasant as possible for each resident. We appreciate your assistance as we work toward that goal. If you have any questions or concerns, please contact me at your convenience.

Sincerely,

Click or tap here to enter text., Click or tap here to enter text.

Appendix E—Sample Discharge Notice

Click or tap to enter a date.

Click or tap here to enter text.

Click or tap here to enter text.

Click or tap here to enter text.

Choose an item. Click or tap here to enter text.:

This letter serves as a notice of discharge from Click or tap here to enter text..

The reason for discharge is Click or tap here to enter text.

The anticipated date of your discharge is Click or tap to enter a date..

The location to which you will be moving is Click or tap here to enter text..

You have a right to relocation assistance and to be prepared for and oriented to being discharged. A separate notice will be provided inviting you and others to a discharge planning conference.

You have a right to contact an advocate to discuss this notice and to seek assistance. You may call or write to an Ombudsman (for persons age 60 and older) or a representative from Disability Rights Wisconsin (for persons under age 60.)

Board on Aging and Long-Term Care

Click or tap here to enter text.

Click or tap here to enter text.

Click or tap here to enter text.

800-815-0015

Disability Rights Wisconsin

Click or tap here to enter text.

Click or tap here to enter text.

Click or tap here to enter text.

Click or tap here to enter text.

You may appeal this discharge decision by:

1.) **Writing a letter** within seven days of having received this notice to the regional office of the Wisconsin Department of Health Services (DHS), Division of Quality Assurance (DQA) asking for a review of this discharge decision and stating why this discharge should not take place.
2.) **Sending a copy** of the appeal letter to the administrator of this facility.
3.) Within five days of having received your written appeal, the facility must provide written justification for the

discharge to DHS, DQA.

4.) If you have filed a written appeal within seven days of receiving this notice, you may not be discharged until DHS, DQA has completed its review and notified both you and the facility of its decision within 14 days of having received written justification from the facility.

The name, address, and phone number for the regional office of the DHS, DQA is:

DQA Regional Office

Click or tap here to enter text.

Click or tap here to enter text.

Click or tap here to enter text.

Click or tap here to enter text.

The name, address, and phone number of this facility's administrator is:

Click or tap here to enter text.

Click or tap here to enter text.

Click or tap here to enter text.

Click or tap here to enter text.

Click or tap here to enter text.

Please contact me with any questions about this notice or your impending discharge from this facility.

Thank you,

Click or tap here to enter text.

Click or tap here to enter text.

Click or tap here to enter text.

cc: Click or tap here to enter text.

Click or tap here to enter text.

Click or tap here to enter text.

Appendix F— Relocation Stress Syndrome—Sample Care Plan

Problem	Goal	Interventions
Resident at risk for signs/symptoms of Resident Relocation Stress Syndrome (RSS) as evidenced by: • Dependency • Confusion • Anger • Depression • Withdrawal • Behavioral changes	Resident will have any signs/symptoms of RSS prevented/mitigated. Resident will choose placement in an appropriate alternate setting. Resident will maintain current functional status.	1. Encourage presence of resident support persons when closure is announced (for example, family, legal representative, caseworker). 2. Identify the facility relocation coordinator for the relocation process for the resident and representatives. 3. As indicated, provide a list of potential contacts such as advocates, county staff, Aging and Disability Resource Center (ADRC). 4. Provide the opportunity for residents and family to verbalize fears and concerns. 5. Acknowledge the resident's right to choose their alternative living setting. 6. Ensure the resident is involved in all aspects of their relocation. 7. Assign a primary staff person for the resident to relate to during the relocation process. Provide for continuity of direct caregivers. 8. Update the interdisciplinary assessment/individual service plan to reflect the resident's desires and

Problem	Goal	Interventions
		needs for consideration in relocation. 9. Coordinate the resident planning conference to identify potential relocation settings seeking an alternate living setting. 10. Coordinate visits and tours of potential facilities for relocation. Encourage the resident, family, and/or guardian to tour. 11. Monitor the resident for any changes in behavior related to the relocation process. 12. Identify the resident's past coping techniques and, if indicated, determine a plan for using those in the current relocation situation. 13. Monitor the resident for any changes in physical status. 14. Coordinate the actual physical move to the new alternate living setting. Assign a staff person to accompany the resident and assist in settling them. As indicated, discuss with new staff the resident's cares, specific needs, and unique characteristics.

Appendix G—Relocation Stress Syndrome/Transfer Trauma—Staff Education

The following content has been developed for staff education.

Goals of the training program:

1. Ensure the rights of each resident are observed during the relocation process and that each resident experiences a safe and appropriate relocation while minimizing negative outcomes for the resident (Hirdes J et al).
2. Ensure all staff are aware of what transfer trauma (TT) is and what their role in prevention and identification is.

Resident Rights

- Right of privacy
- Right to make choices about health care
- Right to be free from abuse
- Freedom from interference, coercion, and discrimination
- Right to voice grievances

Resident Rights—Relocation Process

- Right to adequate care and treatment in the least restrictive/most integrated setting
- Right to be informed and receive adequate notification of discharge decisions
- Right to reasonable accommodations of needs and preferences

Definition of Relocation Stress Syndrome/Transfer Trauma

1. A set of symptoms and negative outcomes that may result for a resident during the process of relocation from one environment to another (Hirdes J et al)
2. Physiologic and/or psychosocial disturbances as a result of transfer from one environment to another ("Role of the Long Term Care Ombudsman in Nursing Home Closures")

Symptoms/Characteristics

Depression	Hallucinations
Anger	Unwillingness to move
Loss of trust	Being upset
Insecurity	Indecision
Anxiety	Perceived loss of control
Fearfulness	Delirium
Excess need of reassurance	Sleep Disturbances

Thought intrusion	Loss of immunocompetence
Despair	Pressure sore formation
Crying	Change in eating habits
Confusion	Weight change (usually loss)
Loneliness	Stomach problems
Withdrawal	Falls
Resistance	Increased complaints of pain
Aggressiveness	

(Hirdes J et al and Ombudsman Program)

Important Note

1. Some symptoms or characteristics will be obvious and easily identified, such as changes in the resident's health, personality, or behavior.
2. For some residents, the changes will be subtle so that it is important to report any and all changes to a nurse for further assessment and follow-up.

Strategies for Transferring Facility

- Assess resident and implement a temporary care plan to ensure the process is resident focused and the resident's needs are met.
- Assess resident preferences.
- Ensure fluid communication to all involved parties regarding discharge developments and referral outcomes.
- Provide for the exchange of information between providers.
- Foster face-to-face meetings with the resident and their family/guardian.
- Encourage resident to be directly involved.
- Encourage family/guardian to be involved.
- Provide interdisciplinary team support.
- Educate staff on the process and what to expect.
- Provide the opportunity and time for the resident to talk and ask questions.
- Listen to the resident and their family/guardian.
- Maintain daily routines.
- Be flexible as the resident's needs change.
- Be aware that resident feels loss of control.
- Encourage frequent one-on-one visits with familiar staff.
- Provide a list of possible relocation sites.
- Assist with scheduling visits to possible relocation sites.

- Once a relocation facility is chosen, assist with the transfer of information.
- Upon acceptance at a relocation facility, assist with paperwork transfer.
- Dress in "finest."
- Allow time for resident to say farewell to staff and peers.
- Allow a "familiar face" to accompany the resident to new site.

Tips for Residents and Families

- Read admissions agreement.
- Share expectations.
- Communicate concerns as soon as possible.
- Contact Ombudsman as advocate.

Strategies for Receiving Facility

- Know resident may be experiencing emotional and physical symptoms.
- Provide primary contact for new resident and family/guardian.
- Address risk for TT (for example, falls, anxiety, and weight loss) in the admission care plan.
- Document resident's reaction and concerns on the day of the move.
- Create a warm and friendly environment.
- Unpack with the resident.
- Introduce the resident to peers, volunteers, and families.
- Establish a routine.
- Assign consistent caregivers.

Assess for Risk of Relocation Stress Syndrome/Transfer Trauma

- Assess for changes in activities of daily living (ADL) performance.
- Assess for changes in behavior.
- Assess for changes in nutritional status, weight loss, change in appetite, risk for dehydration.
- Assess for behavior changes and depression.
- Use Minimum Data Set tools and risk assessment tools.

Care Plan Interventions

- Allow resident to verbalize.
- Keep resident actively involved.
- Monitor for changes in behavior.
- Monitor for changes in abilities (ADL, mobility).
- Monitor for decline in cognitive status.
- Monitor appetite intake and output.
- Document weekly weights and look for changes.
- Monitor for complaints of increased pain.

Section X: Optional Sample Forms

Discharge Information Packet Checklist

Resident: Click or tap here to enter text.

Discharge Date: Click or tap here to enter text.

Please verify that these documents are current and accurate. Initial and sign on the lines provided next to each item.

Date	Initials	Items
_____	_____	MD order to discharge to:
_____	_____	History and Physical
_____	_____	Copy of most recent physician progress note
_____	_____	Copy of PASRR
_____	_____	Copy of immunizations
_____	_____	Next MD appointment needed or made
_____	_____	Medications ordered to be sent with resident
_____	_____	Face sheet
_____	_____	Copy of Guardianship/Power of Attorney (POA)/Power of Attorney for Health Care (POAHC)/Case Worker paperwork
_____	_____	Social Service Discharge Assessment
_____	_____	Discharge summary and recapitulation
_____	_____	Behavior Check List
_____	_____	Behavioral treatment plans/contracts
_____	_____	Behavior target sheets
_____	_____	Social history
_____	_____	Nurses notes for the last four weeks

Date	Initials	Items
_____	_____	Most current physician orders
_____	_____	Current month's med sheets
_____	_____	Current month's treatment sheets
_____	_____	Copies of lab and diagnostic tests for the last three months
_____	_____	Most recent MDS (Date:)
_____	_____	Financial Reconciliation
_____	_____	Possession Inventory

Discharge Planning Process Checklist

Resident: Click or tap here to enter text.

Complete	Date Completed	Discharge Planning Process	Follow Up Needed/Comments
☐	Click or tap to enter a	Facility closure notice given	Click or tap here to enter text.
☐	Click or tap to enter a	Initial planning conference meeting	Click or tap here to enter text.
☐	Click or tap to enter a date.	Schedule meeting Date: _____	Click or tap here to enter text.
☐	Click or tap to enter a	Letter sent—Confirmation of meeting	Click or tap here to enter text.
☐	Click or tap to enter a	Waived meeting—return letter	Click or tap here to enter text.
☐	Click or tap to enter a date.	Meeting held ____ in person ____Other: _____	Click or tap here to enter text.
☐	Click or tap to enter a	Resident present	Click or tap here to enter text.
☐	Click or tap to enter a	Responsible party present	Click or tap here to enter text.
☐	Click or tap to enter a	Review of relocation process completed	Click or tap here to enter text.
☐	Click or tap to enter a	Review of discharge options completed	Click or tap here to enter text.
☐	Click or tap to enter a	Review of rights/appeal rights	Click or tap here to enter text.
☐	Click or tap to enter a	Release of information process reviewed	Click or tap here to enter text.
☐	Click or tap to enter a	Review of D/C goals	Click or tap here to enter text.
☐	Click or tap to enter a	Onsite visit scheduled—potential location	Click or tap here to enter text.
☐	Click or tap to enter a	Onsite visit completed—potential location	Click or tap here to enter text.
☐	Click or tap to enter a	POA/Guardian in place	Click or tap here to enter text.
☐	Click or tap to enter a	30-day notice given—specific location	Click or tap here to enter text.
☐	Click or tap to enter a	Discharge planning conference scheduled	Click or tap here to enter text.

Discharge Planning Process Checklist Sample—Page 2

Complete	Date Completed	Discharge Planning Process	Follow Up Needed/Comments
☐	Click or tap	Discharge planning conference held	Click or tap here to enter text.
☐	Click or tap	Arrangements made to transfer funds	Click or tap here to enter text.
☐	Click or tap to enter a	PASRR completed and up to date _____ Date	Click or tap here to enter text.
☐	Click or tap to enter a	Day of move planned; scheduled moving of belongings and transportation for resident	Click or tap here to enter text.
☐	Click or tap	Determine support needs	Click or tap here to enter text.
☐	Click or tap	Equipment needs	Click or tap here to enter text.
☐	Click or tap	Adaptive equipment	Click or tap here to enter text.
☐	Click or tap	Wheelchair	Click or tap here to enter text.
☐	Click or tap	Other durable medical equipment	Click or tap here to enter text.
☐	Click or tap to enter a date.	Community placement needs Home health Therapy meals Other	Click or tap here to enter text.
☐	Click or tap to enter a date.	Education completed Medication administration Treatments Diagnosis Nutrition Leisure Other	Click or tap here to enter text.
☐	Click or tap to enter a date.	Assessments Completed—Final Nursing Social services Nutrition Other	Click or tap here to enter text.
☐	Click or tap to enter a	Discharge Transportation Set	Click or tap here to enter text.

Discharge Planning Process Checklist Sample—Page 3

Complete	Date Completed	Discharge Planning Process	Follow Up Needed/Comments
☐	Click or tap to enter a	Follow-up clinical appointments	Click or tap here to enter text.
☐	Click or tap to enter a date.	Documentation sent with resident	Click or tap here to enter text.
		For D/C	
		Physician orders Rx, if needed	
		Medications sent	
		Nursing assessment	
		D/C summary	
		History and physical	
		Communicable disease statement	
		Immunization records	
		Electronically transfers in system care plan	
		Social Service Documentation	
		Other:	
☐	Click or tap	Personal belongings inventory sent	Click or tap here to enter text.
☐	Click or tap to enter a	Relocation stress information sent to facility	Click or tap here to enter text.

Discharge Planning Process Checklist Sample—Page 4

Complete	Date Completed	Discharge Planning Process	Follow Up Needed/Comments
☐	Click or tap to enter a date.	Final documentation completed Nursing Social services MD	Click or tap here to enter text.
☐	Click or tap	Discharge summary completed	Click or tap here to enter text.
☐	Click or tap	Close medical record	Click or tap here to enter text.
☐	Click or tap	Post-discharge plan of care and follow up	Click or tap here to enter text.
☐	Click or tap to enter a date.	Notification of change of address Post Office Social Security, Medicare, Medicaid Other	Click or tap here to enter text.
☐	Click or tap to enter a date.	Place on discharge tracking log Name New address Responsible Party Information Case Worker Contact information	Click or tap here to enter text.

☐

Additional Notes: Click or tap here to enter text.

Completed By: Click or tap here to enter text.

Signature: _____ Date: Click or tap to enter a date.

Discharge Planning Summary

Resident: Click or tap here to enter text.

MR# (if applicable): Click or tap here to enter text.

Discharged to (name and address):

Click or tap here to enter text.

Discharged With Whom/Relationship:

Click or tap here to enter text.

Discharge Date: Click or tap to enter a date.
Time: Click or tap here to enter text.

Transportation: ☐ Family ☐Friend ☐Medical Van
☐Other: Click or tap here to enter text.

Home Health Agency: Click or tap here to enter text.

Agency Contact Person: Click or tap here to enter text.
Phone: Click or tap here to enter text.
Fax: Click or tap here to enter text.

Nursing Skilled Services Recommended (Check all that apply.)

☐ Hospice wound care pain management

☐ Med set up, IV

☐ Tube feeding

☐ Oxygen

☐ Diabetic teaching and training

☐ Other: Click or tap here to enter text.

Rehabilitation Therapies

☐ Physical therapy

☐ Occupational therapy

☐ Speech

☐ Home safety evaluation

☐ Home health aides (Bath assist)

☐ Social worker

☐ Other: Click or tap here to enter text.

☐ No skilled services indicated/requested

Date Discharge Order Received: Click or tap to enter a date.

Equipment Recommended: Click or tap here to enter text.

Primary Care Management Agency: Click or tap here to enter text.

Phone: Click or tap here to enter text.
Start Date: Click or tap to enter a date.

Community Resources/Additional Information:

Click or tap here to enter text.

Family Contact: Click or tap here to enter text.
Phone: Click or tap here to enter text.

Participation: Click or tap here to enter text.

Social Worker: _____
Date: Click or tap to enter a date.

Guide for Resident/Family/Guardian During Relocation Process

The relocation process is often an emotional and difficult task for residents, families, and guardians. These materials have been developed to assist and guide individuals through the process. Individuals will receive support from designated facility staff and from representatives at various agencies. It is important for individuals to participate in the person-centered discharge planning process to determine the most appropriate relocation options and to visit several potential residences, if possible. Be sure to use the Comparison of On-Site Visits Form during visits. At any time in the process, discuss concerns with and direct questions to facility representatives.

Facility Contact Name: Click or tap here to enter text.

Facility Contact Phone Number:
Click or tap here to enter text.

Notes From the Resident/Family Meeting
Click or tap here to enter text.

Tasks for the Resident, Family, and/or Guardian During the Relocation Process:

☐ Discuss needs, wishes, and/or concerns with facility designee.

☐ Participate in an initial planning conference.

☐ Visit potential residences.

☐ Use the Comparison for On-Site Visits guide.

☐ Discuss visits with the facility designee to decide upon new residence.

☐ Remove valuable or irreplaceable items (only at resident's request/approval).

☐ Add a list of items removed to the resident's clinical record.

☐ Ask questions and voice concerns throughout the process.

☐ Participate in a final discharge planning conference to finalize the details of the move.

☐ Assist the resident to complete a postal change of address.

☐ Offer support to resident during transfer.

☐ Complete the admission process at the new location.

Comparison of On-Site Visits

This guide can assist individuals in recording information and making informed decisions regarding a new residence. They are encouraged to carry the guide with them when visiting; it will help individuals compare multiple locations. Listed below are some areas individuals may want to be aware of during their visits as well as some questions they may want to ask. Not all questions are applicable to each type of relocation setting and the list is not all-inclusive.

	Name of Residence	Contact Person	Phone Number	Date of Visit
A				
B				
C				

	A Yes/No	B Yes/No	C Yes/No
1. Is the general atmosphere warm, pleasant, and cheerful?			
2. Do staff show genuine interest in and affection for residents?			
3. Do residents look well cared for and generally content?			
4. Is the residence clean and orderly?			
5. Is the residence free of unpleasant odors?			
6. Does the residence offer designated smoking areas?			
7. Are call lights answered within a reasonable time frame?			
8. Does the food look appetizing with adequate serving sizes?			
9. Do residents who need help eating receive assistance?			
10. Does the residence offer activities that you would enjoy?			

	A Yes/No	B Yes/No	C Yes/No
11. Are activities offered for residents who are relatively inactive, confined to their rooms, or cognitively impaired?			
12. Do residents have an opportunity to attend religious services and talk with their clergymen, both in and outside the home?			
13. Is fresh drinking water within reach of the resident?			
14. Do staff knock before entering a resident's room?			
15. Is there a lounge where residents can chat, read, play games, watch television, or just relax away from their rooms?			
16. Does the residence have an outdoor area where residents can get fresh air and sunshine, and do residents use this area freely?			
17. Did the residence's representative ask about your (or your family member's) specific needs and preferences?			
18. Would you be satisfied living here?			
19. Do you have adequate information about this residence to make a decision?			

Suggestions for Supporting the Resident During Transfer

Once the resident is scheduled and prepared for relocation, the resident will need additional support during the transfer to the new residence. The resident's medical and psychosocial status will be considered to determine the most appropriate mode of transportation. Family members and staff will be encouraged to escort the resident to their new residence. The following steps should be considered during resident transfer:

1. Check if the resident is prepared to go before the vehicle arrives (belongings packed, changed into clean clothes, last minute primping, etc.).
2. Inform the resident when the vehicle arrives.
3. Load the president's personal belongings into the vehicle.
4. Allow the resident ample time to say good-bye to other residents and staff.
5. Adjust the vehicle's temperature for the resident (air conditioning or heat).
6. Escort the resident at the resident's pace to the transfer vehicle.
7. Comfort the resident.
8. Talk calmly with the resident.
9. Use physical contact to calm the resident.
10. Offer reassurance to the resident about the move.
11. Go at the resident's pace—do not rush the resident.
12. Indicate the location of the resident's belongings (in the vehicle, family has them, etc.).
13. Reduce the noise within in the vehicle—consider comforting music.
14. If using a wheelchair lift:
    - Show the resident how it works.
    - Explain to the resident what to expect (noise, movement, etc.).
    - Offer to ride on the lift with the resident, if acceptable to the driver.
15. When entering a bus or passenger van, point out the railings and steps to the resident.
16. If multiple residents are transferring on the same vehicle, consider staying on the bus with the residents while others are boarding.
17. Once at the new residence, assist the resident into the building.
18. Stay with the resident while their belongings are being unloaded.
19. Offer to assist the resident in setting up their room.