

**November 1, 2010
Resident Relocation
Manual**

**For
Nursing Homes Facilities
Serving People with
Developmental Disabilities
Community Based Residential Facilities**

**Department of Health Services
Division of Long Term Care**

Introduction and Acknowledgements

This manual offers guidance and direction to nursing homes, Facilities Serving People with Developmental Disabilities (FDD) and Community Based Residential Facilities (CBRF) that are relocating residents under the requirements of Chapter 50, Wis. Stats. The manual also has much to offer all of the agencies and organizations that become involved in relocating residents from these facilities.

The intent of the statute, as well as this manual, is to diminish the effects of the Relocation Stress Syndrome (RSS), formerly known as “transfer trauma.” Facility staff should receive training in how to identify and address Relocation Stress Syndrome as soon as possible after a resident relocation effort is announced. Training resources are located in Section VII of this manual.

This Resident Relocation Manual explains the basic requirements including sample templates for the submission of the Chapter 50, Wis. Stats, Resident Relocation Plan. An approved plan will become the roadmap for all stakeholders in directing their energy and resources.

In the best interest of residents, staff and owners, a facility should communicate with the 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. Representatives from the facility, the Aging and Disability Resource Center(s) (or in some regions the county human services system), consumer advocacy agencies, and the state Department of Health Services comprise the State Relocation Team. The DHS team members include the State Relocation Team Lead and the Member Care Quality Specialist (MCQS) assigned to MCOs operating in the county (ies) where the relocating residents are from.

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. When resident relocations are undertaken in a spirit of mutual respect, residents will benefit during the process and they will achieve good outcomes; and all involved will have fulfilled their responsibilities.

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 Section II of the manual. A thorough review of the regulations related to resident relocation during the facility’s decision making process is strongly recommended.

The Division of Long Term Care is grateful to the many stakeholders who have contributed to the creation and evolution of this manual over the past ten years. We acknowledge many dedicated staff persons from the Division of Quality Assurance, Area Administration, the Division of Mental Health and Substance Abuse Services, the Ombudsman Program and Disability Rights Wisconsin who have stayed with us in this endeavor. We also acknowledge contractor Pathway Health Services for their lasting contributions to earlier versions of this manual.

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Section I

**Immediate/Initial
Contact
With**

**The Department of Health Services
Division of Long Term Care
Resident Relocation Coordinator**

Technical Assistance

The contents of the Relocation Manual are designed to guide closing or downsizing 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. Department consultation and technical assistance are always available to facilities by contacting the Division of Long Term Care Relocation Coordinator.

Submission of a Resident Relocation Plan

Submission Requirements

A facility that intends to downsize or close and will therefore relocate 5 or more residents must notify the Department of its intention, and it must submit a Resident Relocation Plan. As a preliminary step, facilities are strongly encouraged to contact the Division of Long Term Care to arrange an orientation meeting regarding the requirements and processes involved in a resident relocation. The facility's need for confidentiality will be observed.

A facility may obtain immediate verbal consultation on the development of its relocation plan by contacting the Department Relocation Coordinator at the telephone number or electronic mail listed below.

Nursing Homes, Facilities Serving People with Developmental Disabilities (FDD) and Community Based Residential Facilities (CBRF) should submit their notice and Resident Relocation Plan to:

Associate Director
Bureau of Managed Care
1 West Wilson Street, Room 518
Madison, WI 53703
608-267-7286
DHSBMC@wisconsin.gov

Role of the Division of Long Term Care

It is the role of the Division of Long Term Care (DLTC) to monitor the entire resident relocation process. This includes but is not limited to:

- Ensure downsizing or closing facilities understand Chapter 50 and applicable administrative code as they relate to resident relocation, and that these facilities are in compliance with its requirements.
- Approve of the Resident Relocation Plan.
- Ensure resident rights are protected and resident-centered relocation occurs at the systems level as well as individual level and ensure residents' right to choice is respected and honored.

- Lead the State’s Resident Relocation Team.
- Collaborate with Aging and Disability Resource Centers (ADRCs) and Managed Care Organizations (MCO), the IRIS (Include, Respect, I Self-Direct) independent consultants, counties and county waiver programs, and advocacy agencies.
- Refer residents, family members, legal representatives including guardians and facility staff to their Aging and Disability Resource Center regarding eligibility criteria, information and assistance, and service alternatives for community placement.
- Strategize with relocation team members and provide expertise to remove barriers, if any, impeding a person’s relocation.
- Confirm a plan for resident monitoring and staff training regarding resident relocation stress syndrome (RSS).
- Confirm with the facility Administrator the facility staff resources that will be allocated for discharge planning and the relevant experience of designated facility staff.
- Determine with the facility administrator if and when additional staff resources are needed to both operate the facility and manage resident relocation assignments.
- As indicated, conduct follow up outcome evaluations of relocated residents.
- Conduct Lessons Learned Meeting post resident relocation and facility closure to identify strengths of the process and areas needing further strengthening.

TIMING

Timing of the facility’s submission of the Resident Relocation Plan needs to take into consideration multiple factors which include the following statutory requirements:

Section 50.03(14) (e), Wis. Stats., provides that the effective date of the closing may not be earlier than:

1. 90 days from the date a relocation plan is approved by the Department if 5 to 50 residents are to be relocated;

OR

2. 120 days from the date a relocation plan is approved by the Department 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 that date.

Method of Plan Submission

- The Resident Relocation Plan and resident roster are to be submitted to the Division of Long Term Care electronically via email. Residents' personal and health information must be protected at all times.
- Alternative methods of submission include: US Postal Service, commercial delivery service, or hand delivered.

Initial Facility/Department Meeting

When the facility contacts the Division of Long Term Care regarding its intent to submit a Resident Relocation Plan, the Division Resident Relocation Coordinator will schedule an orientation meeting with the facility representatives. If at all possible, this meeting should occur prior to submission of the relocation plan.

Purpose of the Meeting:

- Review the Ch. 50, Wis. Stats, 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 delivery system including Family Care, IRIS (Include, Respect, I Self Direct), and county waiver programs.
- Confirm the facility's commitment to preserve resident rights.
- Inform the Department of potential legal, financial, personnel or operations concerns that may affect the successful relocation of all facility residents.
- Ensure the facility will mitigate relocation stress syndrome for residents, families, staff and other involved persons.
- Answer questions.
- Confirm relocation process time lines.

Ch. 50 Resident Relocation Plan Review and Approval Process

The review process begins upon submission of a facility's Resident Relocation Plan to the Division of Long Term Care. The accuracy and completeness of information contained in the plan will facilitate a smooth review and timely approval.

The facility may be contacted to clarify submitted information or to request additional information. Again, the timeliness of the organization's response is crucial to the Plan approval. The facility will be notified in writing when the Plan is approved.

Planning for or implementing any resident's discharge must not be undertaken until after the facility's Ch 50 Plan has been approved.

Department Plan Review: Approval or Denial Protocols

The Department must respond within ten (10) calendar days of receipt of a facility Resident Relocation Plan; pursuant to sec. 50.03(14) (d), Wis. Stats. The Department's failure to provide a response within 10 days results in automatic approval of the Plan.

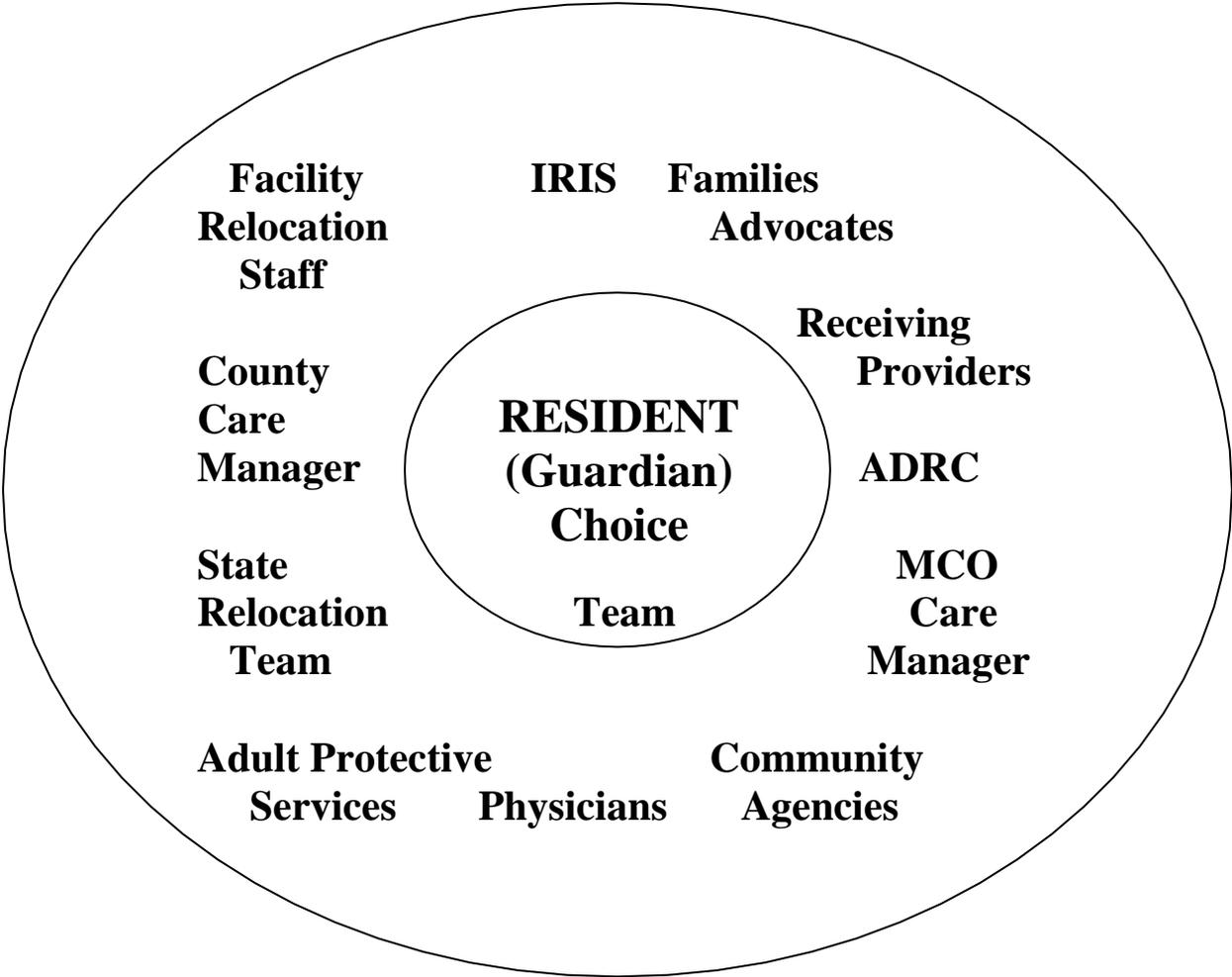
The DLTC will consult with the facility until all components of the Plan are complete and approved. If the DLTC has contact with the facility, either verbally or in writing, to discuss aspects of the Plan that are incomplete, or unclear, or unsatisfactory, or do not meet the intent of the statute, the ten (10) day approval time restarts from the date the DLTC receives an amended Relocation Plan from the facility.

The DLTC will conduct its review of the Plan based on statutory criteria and in consultation with other members of the State Relocation Team. The review will determine whether all statutorily required components are present and satisfactory. The Resident Relocation Plan Review Checklist found in the appendix is a tool the facility and Department can use to determine whether all of the required components are present. See Section VIII Appendix A.

General Information

The information presented in this Resident Relocation Planning Manual is intended to bring about the best possible outcomes for residents, staff, community, service providers and other stakeholders participating in or responsible for the relocation of residents when facilities close or downsize. It is crucial for facilities to involve and collaborate with the Department of Health Services, Division of Long Term Care, throughout this process. In addition facilities contemplating closure or downsizing should thoroughly review all state and federal regulatory requirements, including those of the Department of Workforce Development, which may differ significantly from the requirements in other states.

Resident Centered Relocation



When Chapter 50 Resident Relocation Requirements Apply

Facility Decision to Close Ch 50 Plan Required

The reasons for the decision to close an entire facility or a certain type or level of service will vary and may include: bankruptcy, financial receivership, going out of business, change in service delivery, decline in market or community demand, age and location of physical plant, regulatory compliance problems, loss of provider agreements, the sale of the organization, etc.

When a facility makes a decision to close, the facility is required by sec. 50.03(14)(c)7. Wis. Stats., to notify the Department in writing of its intention to close and relocate residents; and a Resident Relocation Plan must be submitted when ever 5 or more residents will be relocated.

Downsizing by Purposeful Discharge due to Change in Type or Level of Services Generalized Downsizing by Residents' Voluntary Choice to Relocate Chapter 50 Plan Required

When a facility changes a type or level of service, such as closing a distinct part specialty unit, and will therefore no longer care for 5 or more residents who need these services, it must abide by all Ch 50 resident relocation requirements in discharging the affected residents.

Generalized downsizing of a facility when there is no change in the type and level of services provided by the facility is accomplished by each residents' voluntary decision to relocate following the facility's announcement of its intent to downsize. In this case the Chapter 50 Plan will focus on how the facility announces its intent to downsize; and how as well as what information will be offered to residents so they can make informed decisions about where they want to live. Residents have choices, they may choose to stay at the facility and can not be involuntarily discharged; or, they may choose to voluntarily discharge. The facility must not encourage or persuade residents to relocate.

Downsizing by Natural Attrition Ch 50 Plan Not Required

When a facility intends to decrease its licensed bed capacity by natural attrition it will allow census to decline to the desired level through normal day to day discharge occurrences. These discharges are most often due to death, resident decisions to return to their community homes, or to relocate to another region of the state or country, or to transfer to another provider type, etc. Downsizing by natural attrition takes as long as it takes, and it could take many months or years. The facility does not make any additional or concerted effort to encourage resident discharges.

Replacement Facilities Ch 50 Plan Not Required

When a provider builds a new building to replace its physical plant, the facility is not required to submit a Chapter 50 Resident Relocation Plan but must advise the Division of Quality Assurance (DQA) and follow DQA directives. In addition providers are strongly encouraged to contact the Board on Aging and Long Term Care (Ombudsman Program) for technical assistance.

A Note Regarding Employees:

Actions need to be taken which can avoid the possibility of insufficient facility staff due to premature employee resignations. 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, including the requirements found in the Worker Adjustment and Retraining Notification Act (WARN Act) at 20 CFR Part 639.

Section II

**Statutory
And Administrative
Code Requirements**

Links to Statutes and Codes

Relocation Manual

http://dhs.wisconsin.gov/rl_dsl/Providers/relocation.htm

DQA Statutes and Codes

http://dhs.wisconsin.gov/rl_DSL/index.htm

This link will lead to Ch 50, state administrative codes and the Code of Federal Regulations web site.

Click on provider type, click on rules and regulations,
The state administrative code will appear.

For federal regulations, click on CFR, next click on “Retrieve CFR by Citations” Follow Directions.

Statutory Reference Ch. 50

<http://www.legis.state.wi.us/rsb/stats.html>

On the left side of the screen, Type in ch.50, click on “Statutes Related”

Wisconsin Statutory Requirements

STATUTORY BACKGROUND – Applicable Statutes – Please Note: Chapter 50 is all inclusive when referring to “facilities” (in the context of relocation) involved in resident relocations. Facilities refer to nursing homes, Facilities Serving People with Development Disabilities/Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF-ID), and community based residential facilities (CBRF).

The Department of Health Services (Department) has statutory authority under sec. 50.03(14) (a), Wis. Stats., to provide, direct or arrange for resident relocation planning, placement and implementation services in order to minimize the trauma associated with the relocation of residents and ensure the orderly relocation of residents. This gives the Department 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 Division of Quality Assurance (DQA) will provide regulatory oversight as needed.

Section 50.03(5m) (a) 1. – 6. Wis. Stats. Authorizes the Department to remove residents from any facility licensed under this chapter when any of the following conditions exist:

1. The facility is operating without a license.
2. The Department has suspended or revoked the existing license of the facility.
3. The Department has initiated revocation procedures under sec. 50.03(5), Wis. Stats., and has determined that the lives, health, safety or welfare of the residents cannot be adequately assured pending a full hearing on license revocation.
4. The facility has requested the aid of the Department in the relocation of the resident and the Department finds that the resident consents to relocate or that the move is made for valid medical reasons or for the welfare of the resident or of other residents.
5. 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 5 residents or 5% of the residents, whichever is greater.
6. The Department determines that an emergency exists which requires immediate relocation of the resident. An emergency is a situation, physical condition or one or more practices, methods or operations, which 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 Ch. 50, Wis. Stats., DHS 132, DHS 134, DHS 83 and Medicare/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.

Relevant Federal Regulations and Wisconsin Administrative Codes

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

Skilled Nursing Facilities (SNF) Nursing Homes (NH)

WISCONSIN ADMINISTRATIVE CODE CHAPTER DHS 132 (Nursing Home)

A facility licensed under chapter DHS 132, Wis. Admin. Code, 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) 1. - 8. 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 CFR 483

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

1. Section 42CFR 483.12(a) (4) through (7) states the following:

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

- (i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.
- (ii) Record the reasons in the resident's clinical record; and
- (iii) Include in the notice the items described in paragraph (a) (6) of this section.

(a) (5) Timing of the notice.

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

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

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

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

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

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

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

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

(i) The reason for transfer or discharge

(ii) The effective date of transfer or discharge

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

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

(v) The name, address and telephone number of the State Long Term Care Ombudsman

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

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

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

2. Section 42 CFR 483.20(L) (3) states the following:

“(L) (3) A post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.” A post-discharge plan of care means the discharge planning process which includes: assessing continuing care needs and developing a plan designed to ensure the individual's needs will be met after discharge from the facility into the community or other appropriate settings.

Facilities Serving People with Developmental Disabilities (FDD) Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF-ID)

WISCONSIN ADMINISTRATIVE CODE CHAPTER DHS 134

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

1. 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 relocation 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 QMRP, 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. Relocation activities shall include:

- a. Counseling the resident about the impending relocation;
- 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 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 CFR 483

Federally certified Intermediate Care Facilities Serving Persons with Intellectual Disabilities (ICF-ID) must comply with the following federal regulations in addition to state requirements for relocation planning.

Section CFR 483.440(b) (4) (i) through (b) (5) (ii) states the following:

- (b)(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).

- (b)(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.”

Community Based Residential Facilities (CBRF)

WISCONSIN ADMINISTRATIVE CODE: CHAPTER DHS 83

A facility licensed under chapter DHS 83, Wis. Admin. Code, 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 individualized 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 individualized service plan.
- (g). *Reason for discharge or transfer.* The reason for the resident's transfer or discharge.

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 a 30 day written advance notice. The notice shall be explained to the resident or the 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.

4. DHS 83.31(4) (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.

DHS 83.31(4)(d) Department Review of Discharge or Transfer.

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.

Section III

Resident Relocation Plan

Written Resident Relocation Plan Requirements

When an organization decides to close or downsize a facility other than by natural attrition, a Chapter 50 Resident Relocation Plan must be developed and submitted to the Department of Health Services for approval. The Department highly recommends that prior to the approval of the submitted relocation plan, the facility not make any written or verbal announcements of the facility's closing to residents, staff, the public or media. This action will assist in facilitating a collaborative, well-planned approach to the successful relocation of the residents residing in the facility.

The facility Resident Relocation Plan at a minimum shall include:

1. Provision for the facility to notify the Department of its intent to relocate residents:

The notification will include: the date and reason for facility closure, for changing the type or level of services or the means of reimbursement or for the downsizing of the number of facility beds.

a. If the facility is relocating 5 to 50 residents, the proposed closing date may be no earlier than 90 days from the date the Department approves the facility Resident Relocation Plan.

b. If the facility is relocating 50 residents or more, the proposed closing date may be no earlier than 120 days from the date the Department approves the facility Resident Relocation Plan.

Note: The facility must remain open until all residents are properly relocated even if the proposed closing date has passed. The facility may close sooner than the closing date if the last resident has relocated to their new home.

Note: An initial verbal closure announcement made to the Department needs to be followed by a written notice of closure.

2. Name of the individual who will function as the facility relocation coordinator.

3. A proposed timetable for planning and implementation of facility closure/resident relocations.

4. The resident census at the time of the plan submission or the census on the day the closure was announced or became known to residents and their representatives. The resident census will be the one reflected on the date the first of these events occurred.

5. Full completion of all the data elements of the Resident Roster. See Section VIII Appendix B. Note the following included points need to be observed when completing the roster.

a. The Department must receive all requested resident roster information before the Resident Relocation Plan can be approved. See Appendix C for specific items to be included on the resident roster.

b. The roster must include a listing of residents who the facility has determined may need to be assessed for guardianship under s.54.10 (3).

c. All communication/usage of the roster must provide for Protected Health

Information (PHI) security.

- d. The facility must update the roster and keep it current at all times.
- e. The results of any prior resident options counseling is noted in the comments section of the roster.

6. The means the facility will utilize to inform staff of the plans for facility closure or downsizing and the relocation of residents. How the facility will address staff stress at the loss of jobs and relationships and how the facility will act to retain necessary staff to facilitate resident care. See Section VII.

7. Initial Announcement of Closure and Relocation of the Residents. The means the facility will utilize to notify the residents, legal representatives and families of the plan to close or downsize the facility and relocate the residents including written notification.

- a. Notification of residents and/or their legal representatives and persons designated by the residents of the announcement meeting. The communication will include the date and time of the announcement meeting. See Section VIII, Appendix D for a sample letter.

For purposes of confidentiality, the initial announcement of the meeting may or may not include the purpose of the meeting. In this case the announcement meeting must be followed by a letter to all residents/legal representatives/families announcing the closure: the tentative date and reason for closure must be included.

- b. Announcement Meeting(s). The announcement meeting participants will include facility staff, the state relocation team lead, the DLTC Member Care Quality Specialist assigned to MCOs operating in the county (ies) where the residents are from, staff from the advocacy agencies, representatives of the ADRC and/or staff from the county waiver programs, and representatives of any residents' managed care organization (MCO). The facility and the state relocation team lead will collaborate on the scheduling and content of the meeting.

- c. The means of notification of attending physicians and the county. See Section VIII, Appendices E and F for sample letters.

- d. The facility may include in the initial announcement the following entities:

- Municipalities
- Legislators
- Other key stakeholders

8. Initial Informational Meeting for Residents/Families/Legal Representatives. The informational meeting usually occurs a few days after the initial announcement meeting and will include the relocation team members from the announcement meeting and may include some or all of the following representatives:

- a. Aging and Disability Resource Centers (ADRCs), Managed Care Organizations (MCOs), IRIS (Include, Respect, I Self Direct) Independent Consultants, and select other agency representatives as appropriate.

- b. The facility may provide, at this family and resident informational meeting, the opportunity to schedule individual relocation planning meetings to reinforce information received at the meeting regarding placement alternatives and to provide opportunities to seek out resident preferences for placement. The ADRC or county waiver programs may choose to schedule residents for options counseling if the residents desire this assistance at this time.
 - c. The facility will create an area with resources to assist the resident and/or their representatives in identifying possible alternate placements and explaining county waiver program, ADRC, MCO and IRIS services available to them for community placement. Additional resources may include facility directories and other community provider informational hand outs.
9. A description of how and when the facility will involve the Aging and Disability Resource Center or county waiver program staff in the planning for the relocation of residents. Adult Protective Services (APS) may also need to be included. If the county of legal and/or financial responsibility is different from the one the facility is located in, the facility needs to inform that county of the need to relocate residents. It is strongly recommended that the county or counties and/or ADRC be contacted as soon as possible, even before the Chapter 50 Resident Relocation Plan has been approved. Facilities should inform the county/ADRC of the time line for the initial resident and family closure announcement meeting and the subsequent informational meeting so that the county/ADRC resources can be scheduled to assist on a timely basis with the facility's Resident Relocation Plan implementation.
10. The resources, policies, and procedures that the facility will provide or arrange for in order to plan and implement the resident relocations. This includes the facility plan:
- a. To mitigate relocation stress syndrome/transfer trauma.
 - b. To address the special needs of persons with a mental illness, an intellectual disability, a physical disability, or other residents who are relocating.
 - c. To identify approaches the facility staff will initiate to assist the resident with the relocation process.
 - d. To address resident preference/choice for relocation settings.
 - e. To provide opportunity for the resident to visit potential alternate living arrangements and provide for transportation.
 - f. To identify the process the facility will initiate to comply with Wis. Stat. Chapter 50.03(14)(c)8.e. pertaining to the identification of residents the facility believes to be incompetent.
 - g. A description of the medical record documents that will be included in the transfer of resident records. Minimally these records shall include:
 - Physician history and physical, and physician orders.
 - Medication Administration Record.
 - Record of current treatments.
 - Relevant consultation reports
 - Nursing Notes from the last 30 days.
 - The most recent complete minimum data set.
 - The most recent quarterly minimum data set.

- The interdisciplinary care plan.
- The nurse aide care plan or instruction sheet.
- Recent social service notes.
- PASRR documents if the resident has a developmentally disabled and/or mental illness diagnosis.
- Recent resident weights.
- Discharge Summary including information on the presence or absence of characteristics of resident relocation stress syndrome.
- Legal documents: power of attorney, guardianship and protective placement records.
- If the closing facility is a community based residential facility, all records similar to the above list need to be included and as noted in DHS 83.31(7).
- If the closing facility is an ICF-ID all records similar to the above list need to be included and as noted in DHS 134.47(4)(k).
- If the closing facility is a nursing home all above records and as noted in DHS 132.45(5) (L) 1-8.

11. Resident Relocation Planning Conference. How the facility will conduct relocation planning conferences with each resident and/or their representatives as required under 50.03(14) (c) 5 and implement the individual relocation plan developed under this statute.

The following components will be addressed:

- a. A written notice of the initial relocation care planning conference will be sent to the resident or decision maker 7 days or sooner before the planning conference. The resident may choose to be referred to the ADRC or county waiver programs for options counseling prior to this initial planning meeting. This choice may influence the timing and content of the relocation planning conference. Also the choice to enroll in Family Care, Family Care Partnership or IRIS will affect the facility role in relocation planning. The facility relocation plan will acknowledge, as indicated, the role of the ADRC and the MCO in resident relocation planning. See Section VIII, Appendix G for a sample planning conference notice.
- b. At each planning conference, an individual relocation plan will be developed with the input of the resident, legal representative, if any, family and physician, as well as the MCO if the resident is a member, or the county waiver program staff, as indicated, and other appropriate professionals involved in the care and treatment of the resident. The resident's family/legal representative will be invited to the planning conference, as practicable, unless the resident requests that family not be present. If the resident would like an advocate present at the planning conference, the facility will notify the advocate of the date and time of the conference.
- c. The planning conference is resident centered. The relocation process is focused on the resident's and/or legal decision maker's preferences/choice for an alternate

- living environment. The resident and/or representative must be actively involved. The timing of relocation planning conferences needs to accommodate resident and representative schedules including week ends and evenings.
- d. As a result of the relocation planning conference, the resident may be referred for options counseling by the ADRC or the county waiver program.
 - e. An assessment of the individual's continuing care needs and needs for relocation supports. Assessing and care planning for individual resident relocation stress syndrome/transfer trauma. See Appendix H for a sample care plan that addresses resident RSS.
 - f. Services that are needed to effect a positive relocation and how services will be accessed.
 - g. Note the facility's responsibility to transport residents to tour possible relocation destinations if other arrangements are not available to the resident.
 - h. If indicated, how the facility will meet the responsibility to assist with the procurement of needed medical equipment.
 - i. How the facility will meet the responsibility to provide needed interventions and procedures to effect a healthful relocation e.g. TB skin tests, etc.
 - j. When indicated a description of the training that will be offered, prior to relocation, to the resident/caregiver to meet care needs of the resident after discharge.
 - k. When indicated, how the facility will meet the responsibility to contact Social Security, assist resident with application for Supplemental Security Income (SSI) and Medicaid, notification of address change, notification of move date.
 - l. A description of how the facility will consult the physician regarding the effects of the potential relocation on the resident's health and how the facility will involve each resident's physician in the resident's planning conference.
12. A description of how the facility will work with residents and their families/guardians to resolve complaints or concerns.

13. The facility will attempt to resolve any grievances voiced by residents, guardians, agents and family members that relate to the relocation process as follows:

- a. The facility will not make any reprisal against an individual for initiating a grievance.
- b. Any grievance will be brought to the attention of the facility's Administrator, who will review the grievance and provide a response to the aggrieved party within five calendar days after the initial presentation of the grievance to the facility Relocation Coordinator. This step will involve oral communications.
- c. If an individual files a grievance, the facility Administrator will provide written notice and actively assist that individual to contact, at any time, an Ombudsman or Disability Rights Wisconsin staff person to assist in resolving any concerns. For individuals receiving treatment for mental illness or chemical dependency, or for persons with developmental disabilities, the facility will assist in accessing the grievance procedure under DHS 94. The Administrator or facility's Relocation Coordinator will inform the State Relocation Team Leader.

14. The procedure the facility will follow in the event the facility is approved to transfer residents within the facility during progress toward closing the building. This room transfer procedure must follow room transfer policy pursuant to relevant state and federal regulations.

15. Notices: The State Resident Relocation Team will also advise the facility regarding language and timing of required notices with reference to discharge and relocation.

- a. Submit a draft of the proposed 30-day discharge notice provided to residents once the resident and/or legal decision-maker has approved the living arrangement/alternate placement. See Appendices I and J.

Note: the resident may appeal the discharge plan, they may not appeal the fact the facility is closing.

Note: These items must all be included in the notice:

- i. Reason for discharge
- ii. Effective date of discharge
- iii. Location to which the resident will be discharged
- iv. A statement that the resident has the right to appeal this transfer or discharge decision to the State of Wisconsin by written letter to the appropriate Division of Quality Assurance Regional Office.

- v. Provision of the name, address, and telephone number of the Long Term Care Regional Ombudsman for individuals over the age of sixty (60) years.
 - vi. If the resident is determined to be chronically mentally ill, physical or intellectual disabilities or under the age of sixty (60), the facility must also list the state's protection and advocacy agency, Disability Rights Wisconsin, and provide that agency's, address and telephone number.
- b. Submit a draft of the proposed written notice of the formal discharge planning meeting to be sent to each resident/legal decision maker at least seven (7) days prior to the meeting day, which day must be at least 14 days prior to any discharge date, and any other noticing requirements pertaining to the facility specific licensure type. See Appendices K and L.
- c. A provision for sending written notice to the attending physician and the appropriate county agency or Managed Care Organization at the time the letters described in a. and b. are sent.
- d. Provision of waiver forms for the above 30 day notice and discharge planning meeting. If a resident's discharge is to take place in less than 30 days from the date of the written notice, the resident or the resident's guardian or agent, if any, may decide whether to waive the thirty day notice requirement and accept the living arrangement. Note: The resident/legal representative may waive the right to the noticed, dated discharge planning conference described above. However the resident has the right to all appropriate discharge planning as indicated in state and federal regulations. See Appendix M.

16. Post Discharge Plan of Care/ Discharge Planning Meeting will address the following points:

- a. Assessment of the resident's status with regard to resident relocation stress syndrome.
- b. Identification of specific resident needs after discharge such as personal care, wound dressings, type of therapy, special diet, etc.
- c. How care will be coordinated if continuing treatment involves multiple caregivers
- d. A description of what agencies will be involved post discharge and the contact individual in each agency (name, role, phone number).
- e. Medications, medical procedure to follow, and the contact person in the closing facility available for follow up questions.

- f. How the facility will provide for the transfer of resident financial accounts to the new facility/provider.
 - g. Identification of a new physician if the resident is unable to retain his/her current physician.
 - h. How the discharge plan will be implemented.
 - i. Family Care, Family Care Partnership, IRIS consultants, and or county waiver program staff should be in attendance and are responsible for the majority of the discharge plan of care including its implementation.
17. As appropriate, the facility's plan to provide follow-up of each resident after relocation and to be available for follow-up questions and consultation.
 18. Provision for retention, storage, and retrieval of resident records and appropriate facility records per state law.
 19. The facility's plan to provide status reports to the relocation team regarding efforts to prevent, identify and address Relocation Stress Syndrome.

Note: Appendices N and O contain listings of all required notices and meetings.

Recommendations for Enhancing the Resident Relocation Process

- Facilitating Resident and Family Council Meetings on a regular basis to enhance communication.
- Involving the ombudsman/advocate to regularly participate in resident and family council meetings and other informational sessions.
- Tailoring activities to address the changing environment and focus on move related events i.e., arranging to tour examples of various residential options, holding "going away" parties, or shopping for things needed in a new setting such as household goods or arranging "drive-bys" past new living arrangements to help residents become oriented to new and unfamiliar locations.
- Inviting relocated residents back to the facility for "going away" parties (for remaining residents) and/or to council meetings to reassure current residents that their relocation is going well and hopefully their relocation also will.
- With permission, posting addresses of relocated residents and giving updates on how relocated residents are doing in their new homes.

- Providing training on Resident Relocation Stress Syndrome for residents' families and other representatives.
- Arranging pastoral care, if appropriate, and individualized visitation by volunteers and staff.
- Designating staff to individual residents to monitor condition including any signs and symptoms of resident relocation stress syndrome and to assist with relocation orientation.
- Creating opportunities for regular updates to residents, families and staff on the status of the facility.

Section IV

**Implementation
Of
Resident Relocation Plan
(Relocation Team Roles)**

Implementation of Resident Relocation Plan

Determination of Relocation Team

The Department of Health Services is authorized to establish the Resident Relocation Team under Ch. 50, Wis. Stats. The Division of Long Term Care Resident Relocation Coordinator will determine the composition of the State Relocation Team.

Relocation Team Composition

1. The State Relocation Team is comprised, at a minimum, of representatives of the following key stakeholders:
 - a. DHS State Relocation Team Lead and Office of Family Care Expansion (OFCE) Member Care Quality Specialists (MCQS).
 - b. The Facility.
 - c. The Resident Relocation Specialist Ombudsman or designee Ombudsman from the Wisconsin Board on Aging and Long Term Care (BOALTC) for individuals over the age of sixty (60); and/or staff from Disability Rights Wisconsin (DRW) for individuals under the age of sixty (60) who have developmental, mental and/or physical disabilities.
 - d. Staff from the Aging and Disability Resource Center in the county where the closing facility is located. In counties where Aging and Disability Resource Centers have not yet been implemented, staff from county Human Service Departments, serving the aging and or disabled populations, would be members of the team. If the county of legal and/or financial responsibility is different from the one the facility is located in, appropriate staff from that county would represent the resident on the State Relocation Team. Additionally staff from the responsible county Adult Protective Services Unit(s) may be consulted where there are concerns regarding guardianship and/or protective placement.
2. Other Department Staff who may be asked to review the Resident Relocation Plan, conduct on-site visits or participate as a member of the State Relocation Team on an as needed basis would include the following:
 - a. Program Bureaus within the Division of Long Term Care.
 - b. The Division of Quality Assurance and its various regulatory Bureaus.
 - c. The Division of Mental Health and Substance Abuse Services and its various program Bureaus.
 - d. Area Administration, Division of Enterprise Services.

- e. The Office of Legal Counsel.
3. Liaisons to the Resident Relocation Team
- a. Staff from the Managed Care Organization representing currently enrolled members who are residents of the facility or newly enrolled members.
 - b. Staff from IRIS Independent Consultant Agency.
 - c. Staff from health maintenance organizations/insurance plans who have currently enrolled members who are residents of the facilities.

State Relocation Team

Each of the State Relocation Team Members has a specific role to assume in the resident relocation process. The following are basic descriptions of the roles. Team members may change during the relocation process as resident/client groups change. With each change, the roles and responsibilities will be clarified by the state relocation team lead who will facilitate the continuity of the team process and coordinate team activities.

Goals of the State Relocation Team

The goal of the state relocation team is the coordination and oversight of available resources that assure good outcomes for relocating residents. In order to achieve this goal, the members of the Relocation Team must be able to commit to:

- Ensuring a resident centered focus throughout the relocation process.
- Recognizing the impact of Relocation Stress Syndrome on residents, families and staff.
- Recognizing the impact of the closure on resident and staff relationships.
- Remaining focused on the best outcomes for the residents while respecting their individual right to choose an appropriate alternate placement.
- Encouraging creative and flexible problem solving.
- Recognizing the impact of the closure on the community and its residents.
- Conducting business in a professional and collaborative manner.
- Providing support to receiving facilities and community service providers to assist them in mitigating the effects of relocation stress syndrome on residents and families.
- Prioritizing reliable and inclusive communication systems with all stakeholders involved.
- Evaluating the completed process to establish best practice and address areas of the relocation process needing improvement.

The Functional Role of the State Relocation Team

The State Relocation Team members each bring to the team process the expertise and access to resources needed to support the successful relocation of the residents. The functional role of the team in monitoring all aspects of the resident relocation process is as follows:

- Participate in the initial announcement of closure meeting for residents and their representatives.
- Participate in the resident and family informational meeting conveying the options available for assistance in the relocation effort and their role in ensuring the resident is able to access them and achieve an appropriate alternate setting.
- Facilitate the development of the individualized relocation plan and its timely progression.
- Ensure options counseling is available for all residents.
- Ensure that resident needs, preferences, and choices are met.
- Ensure that the following elements are present in the development of the individualized relocation plan:
 - Residents are assured of their right to participate in their discharge plan.
 - Ensure relocation information is provided to residents and/or their designated decision maker to provide for informed choice.
 - Ensure counties, ADRCs, MCOs and IRIS consultants are involved in fulfilling their responsibilities in helping the residents relocate.
 - The resident relocation plan is implemented and timely progression is maintained.
 - The resident relocation plan is being followed.
 - Areas of concern in the plan are addressed.
- Identify and facilitate the removal of barriers to transition and potential residential options.
- Follow up, post relocation, on any resident whose relocation may have been potentially problematic or may have resulted in an unexpected outcome.
- Be a resource for the resident and facility throughout the relocation process.
- Maintain confidentiality and adhere to the HIPAA (Health Care Insurance Portability and Accountability Act) guidelines relating to health care information.

Role of the State Resident Relocation Team Lead

The State Relocation Team lead facilitates/coordinates the implementation of the relocation plan with the facility and other members of the State Relocation Team. With the facility the State Relocation Team lead coordinates the scheduling and the agenda of the resident/legal representative /family announcement meeting along with the informational meeting that follows. The state team lead is responsible for ensuring necessary contacts with all team members and agency liaisons to the team such as MCOs.

Additionally the state relocation team lead is responsible for the following:

- Maintaining a resident centered leadership style.
- Initial Announcement of Closure and Relocation: Assisting in the planning of the initial resident/legal representative/family announcement of closure meeting and facilitate core team participation.
- Resident and Family Informational Meeting: Coordinating/facilitating the initial resident relocation informational meetings at the facility for residents/legal representative/family to discuss: the plans for closure and relocation, the rights of the residents, roles of the various relocation team members and resources available to assist residents in their relocation.
- Initial Relocation Team Orientation Meeting: Conducting the initial relocation team orientation meeting to facilitate the meeting of team members and explanations of team member roles.
- Serving as a resource to all members of the state relocation team and the other entities coordinating with the team.
- Initiating regular meetings of the relocation team at the facility. Coordinate and organize team efforts.
- Organizing other meetings at the facility with staff, residents and family members and other team members, as indicated.
- Ensuring the coordination and facilitation of the efforts of multiple state and county staff, ADRC, MCOs, IRIS consultants and other service providers who are involved in the relocation of residents.
- Ensuring the ultimate goal of properly relocating all residents to their new homes in a timely fashion.
- Addressing relevant issues and concerns through enhanced communication, problem solving, consultation and training.
- Coordinate and facilitate follow up visits and evaluations for relocating residents who may have experienced an unanticipated outcome.
- Communicating with the Department and its Divisions and Bureaus to explore available funding options and other resources.
- Monitoring the status of onsite facility resources including staffing, supplies, security and staff morale.

- Monitoring the development of resident relocation plans and ensuring the plans are implemented and timely progression is maintained.
- Requesting status reports from the facility regarding efforts to identify and address Resident Relocation Stress Syndrome.
- Ensuring the distribution of facility generated relocation progress reports/updated rosters to other team members as appropriate.
- Meeting weekly with facility representatives to discuss any concerns observed while visiting the facility and receiving operational updates on concerns including staffing, room transfers, available resources and other relocation related concerns.
- After the last resident has relocated, scheduling and conducting lessons learned meetings for Department and relocation team continuous quality improvement purposes.
- Reporting serious regulatory concerns to the Division of Quality Assurance (DQA.)

Role of the Office of Family Care Expansion

The Office of Family Care Expansion (OFCE), located in the Division of Long Term Care, has a capacity building and quality oversight role for relocation of residents. OFCE Managed Care Quality Specialist (MCQS) staff persons work with their assigned Managed Care Organizations (MCO) to plan for and add capacity to serve relocating residents. MCQS staff persons are members of the State Relocation Team. They review relocation plans prior to their approval and they participate in “unanticipated outcome” reviews for relocated residents.

More information on Family Care is available at <http://dhs.wisconsin.gov/LTCare/INDEX.HTM>

Role of the Member Care Quality Specialist

The Office of Family Care Expansion’s Managed Care Quality Specialist (MCQS), assigned to a MCO involved in a Chapter 50 Relocation, is a member of the State Relocation Team. The MCQS updates the relocation team regarding the status of facility residents who are currently enrolled (before the announcement of closure) and of facility residents who are or will be new members of the MCQS’ assigned MCO. Any barriers to relocation or an appropriate relocation are discussed with the team and solutions are sought.

The following activities are performed by OFCE MCQS staff persons:

- Participate in State Relocation Team meetings to assist in problem solving and removing barriers to the successful relocation of residents who are Family Care or Family Care Partnership members.
- Ensure and support MCO staff in the process of establishing good relations with residents to be relocated, families, closing facility staffs, and community providers.
- Provide assistance, when requested by a MCO, for service plan development, positive behavioral approaches, resource development and capacity building.
- Review individualized relocation plans and refer them for further evaluation within OFCE when needed. The review includes facilitating any special approval processes required.
- Provide technical assistance and support to MCOs on alternatives to restrictive measures, potential rights violations and review of restrictive measures/restraint application in conjunction with the MCO and through the Policy Initiatives and Relocation unit of DLTC.

Role of the Facility

The role of the facility is to follow all directives of Chapter 50 and the approved relocation plan. As a member of the State Relocation Team, the facility works in collaboration with all team members to ensure all residents have the choice of an appropriate alternate setting and are properly relocated to their new home.

Facility responsibilities include the following:

- Continue to provide care and services to residents pursuant to all state and federal regulatory requirements.
- Manage the facility responsibilities for relocating residents
- Ensure adherence to processes set forth in the facility's approved Resident Relocation Plan.
- Consult with the State Resident Relocation Team in developing resident relocation plans.
- Work closely with residents and their representatives, Aging and Disability Resource Centers, appropriate county staff including staff from waiver programs and adult protective services, Managed Care Organizations, IRIS and other service providers in planning for resident relocations.

- Provide constantly updated information to the State Relocation Team to assure implementation of an individualized discharge plan for each resident being relocated.
- Present weekly reports to the relocation team and maintain the Resident Roster to keep it current at all times. These reports will include information on the following:
 - All resident relocations.
 - All hospital transfers.
 - Resident Deaths.
 - Status of options counseling and MCO, IRIS, and county waiver program interventions for residents.
 - Individual resident relocation status including status of applications for SSI and Medicaid.
 - Cases involving unresolved or pending guardianship and protective placement issues.
 - Any other barriers to resident relocations.
- Document in each resident’s plan of care the changes and adjustments necessary for a successful transition to a new living arrangement and to mitigate the possibility or effects of RSS/transfer trauma. See Section VII.
- Notify DQA of the date the last resident was relocated from the facility.
- Return the facility license to DQA.

***Note:** Facilities and other community providers receiving relocating residents may not be familiar with the resources in this manual that may assist them in providing for the new resident. Closing facility staff members have a great deal of contact with community providers during the discharge planning process for each resident. During this time facilities should direct community providers to the Relocation Stress Syndrome resources in this manual, giving them copies of the materials and/or directing them to the web site. State Relocation Team members may also contact community providers to familiarize and update them on the effects of Relocation Stress Syndrome. The Resident Relocation Manual address on the Department website is http://dhs.wisconsin.gov/rl_dsl/Providers/relocation.htm.*

Roles and Responsibilities of Key Facility Staff/Leaders

Key facility staff has responsibilities critical to the success of the Resident Relocation Plan. While the entire closure process is a challenge to all involved, it also provides facility leaders with an opportunity to make a significant impact on the quality of life for the residents entrusted in their care. It is especially essential that these key staff provide the initiatives to assist in the mitigation of relocation stress/transfer trauma for residents, families and staff alike.

Administrator

The nursing home/ICF-ID/community based residential facility administrator continues to serve in his/her role with authority and responsibility for the provision of resident care and services, staffing for all departments, financial operations, vendor relations, community relations, security, safety, and function of the physical plant.

The administrator's resident relocation responsibilities include:

- Coordination and notification of the Department of Health Services (DHS) of the intent to close/downsize the facility and its operations.
- Maintaining a resident centered focus leadership style.
- Maintaining timely communication with the State Relocation Team lead in establishing dates and times for meetings including the announcement, informational, and State Relocation Team orientation meetings along with the weekly or bi-weekly State Relocation Team meetings.
- Following the facility's approved relocation plan in all its aspects.
- Preparing and implementing notification protocols as outlined in this Manual.
- Coordination and implementation of an overall communication plan with all stake holders including ADRCs, MCOs, IRIS, and county waiver programs and Adult Protective Services when applicable.
- Assuring compliance with all applicable state and federal laws pertaining to the employment regulations such as the federal WARN Act and the regulations of the State Department of Workforce Development.
- Addressing staff and resident relocation stress syndrome through a coordinated strategy. See Section VII.
- Addressing resident, family and staff concerns/grievances related to the relocation.
- Being responsible for accountability of staff as it relates to the relocation process.
- Developing a strategy to retain necessary staff to meet operational needs.
- Communicating with the state relocation team lead on a frequent basis to ensure the provision of necessary notification of significant change in resident condition, status of relocation activity, and status of facility operations.
- Upon the discharge of the last resident, returning the facility license to the Division of Quality Assurance.
- Providing the State Relocation Team a final completed resident roster.

Director of Nursing

The Director of Nursing (DON) continues to serve in his/her role in ensuring that clinical care and services continue to be delivered in a manner that meets federal and state requirements. The DON must demonstrate strong leadership during facility closure and show support for residents, families and staff throughout this process. The DON is the primary contact with the medical director and attending physicians. In collaboration with the facility administrator, the DON will develop a plan to address staffing issues as the relocation process is implemented and resident census decreases.

The Director of Nursing responsibilities include:

- Assure all staff is trained in the identification and response to signs/symptoms of Resident Relocation Stress Syndrome. See Section VII.
- Maintain a resident centered focus leadership style.
- Support staff in addressing their own relocation stress. See Section VII
- Coordinate resident clinical care and services.
- Ensure clinical records are accurate and up to date.
- Address resident, family and staff concerns/grievances including those related to the relocation.
- Coordinate resident medical and relocation status information with the facility's resident relocation coordinator for transmission to the state relocation team.
- Coordinate communications and interventions with ADRCs, MCOs, IRIS consultants, county waiver program and adult protective services staff.
- Provide resources necessary for the residents' relocation and education needs.
- Assist receiving facility/alternate placement/MCOs in the pre admission assessment process including resident status with regard to relocation stress syndrome.
- Designate staff to be available to consult with staff of the receiving facility/alternate placement and answer resident care questions that may arise after the actual relocation occurs.

Facility's Designated Resident Relocation Coordinator

The facility's relocation coordinator is the key communicator/facility representative on and with the State Resident Relocation Team. The relocation coordinator serves as the primary contact for residents, families, care managers, community agencies, providers, and other applicable stake holders. In collaboration with the facility Administrator, the facility's relocation coordinator provides, on an ongoing basis, the accurate and current resident and facility information to the State Relocation Team.

The facility's relocation coordinator's responsibilities may include:

- Coordinating with the administrator, implementation of the overall communication plan with all stake holders.
- Maintaining a resident centered leadership style.

- Maintaining a current resident roster.
- Educating facility staff as to the role of ADRCs, MCOs, IRIS and county waiver program staff in the relocation process for residents.
- Maintaining the Resident Roster:
 - Date of Discharge.
 - Facility or entity, including home, relocated to including facility name and type, any licensure, address, telephone number, contact person and results of any follow up.
- Coordinating an initial relocation planning conference for each resident.
- Coordinating the discharge planning conference for each resident.
- Communicating at each relocation team meeting the status of each resident's relocation plan as known to the facility.
- Communicating with the State Relocation Team, at each relocation team meeting and as needed, to provide necessary notification of significant change in resident status including health and financial.
- Communicating, along with facility administration, facility operational status.
- Addressing resident, family and staff concerns/grievances as relates to the relocation.
- Facilitating resident tours of prospective alternate placements/settings.
- Facilitating the actual resident discharge to the receiving entity or home.
- Coordinating the physical transfer of belongings and financial accounts to designated locations/entities/persons.
- Ensuring all notices, required by Chapter 50, is initiated for each individual resident.
- As indicated, initiating follow up for residents relocated from the facility.

Social Services

Facility social work staff will continue to provide the psychosocial support and services as required to meet residents' needs and State and Federal requirements. In collaboration with the facility's relocation coordinator, the social worker will assist in facilitating the discharge planning process. The social worker will continue to be an internal advocate for the residents and communicate with the facility administrator and relocation coordinator concerns and grievances as appropriate.

The facility social worker's responsibilities may include:

- Identifying and conveying the resident's decision making status.
- Identifying and conveying the resident's legal status.
- Describing the Preadmission Screening and Resident Review (PASRR) status for residents who may need specialized services or who are receiving them. (nursing homes)
- Identifying special needs of residents that must be considered during placement and conveying this information to the state relocation team and any outside case managers.

- Conveying the individual resident's discharge plan status with reference to assessments performed prior to the closure decision and the results of any prior options counseling via county waiver programs or ADRCs.
- Educating residents and families about discharge options including in the community and possible access through options counseling.
- Providing residents with the opportunity to communicate individually with the advocates on the relocation team.
- Assisting residents/families in determining preferences and choices.
- Arranging transportation and moving assistance within the provider organizations when needed.
- Participating in the individual resident's discharge planning conference.
- Assisting the receiving facility/alternate placement in assessing and receiving the relocating residents.
- Documenting all aspects of the discharge planning process including a final discharge summary.

Role of the Facility QMRP

Both Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF-ID) and skilled nursing facilities with residents receiving active treatment will have Quality Mental Retardation Professionals (QMRP) on staff. The facility QMRP may have various roles during the relocation process. The primary focus of the QMRP should be assuring the resident's health, safety, care, and well being throughout the relocation process. The QMRP activities may include:

- Continued oversight not only of the resident potentially relocating to the community but also residents who remain at the facility.
- Report any concerns of relocation stress (transfer trauma) to facility lead in order for the facility lead person to clearly convey to the State Relocation Team the status of the individual in order to problem solve around the trauma that the resident is feeling.
- Share requested resident information with the relocation team as well as the receiving county/MCO as requested.
- Facilitate discharge meetings with the appropriate team members at the facility/MCO/county level.

Financial – Business Office Representative

The business office representative or designee will continue to be responsible for the security of resident funds, accounts and financial information throughout the closure process.

The facility business office representative may be responsible for:

- Providing accurate financial status for the Resident Roster including specific identification of all payment sources, any known financial assets creating barriers to relocation, and the status of any applications for Medicaid Fee for Service, Family Care, community waiver programs, MCOs, IRIS, Supplemental Security Income (SSI), Social Security (SS), and Veteran's Administration Pensions.
- Providing a final accounting of all funds and accounts upon discharge.
- Ensuring proper transfer of resident funds.
- Assisting in the transfer of financial information to the receiving facility.
- Completing the change of address process for each resident.
- Notifying Social Security, Medicare and Medicaid and other payer sources and service providers, as indicated, of new addresses.
- As indicated, attending the first State Relocation Team meeting to confirm the financial status of each resident.
- Maintaining accurate financial records and documentation.

Role of County Human Services Departments/Waiver Programs

Counties have statutory roles and responsibilities as fully functioning members of the State Relocation Team. The county has the responsibility to provide the necessary support to enable a resident to choose to relocate to a community setting. A county also has the responsibility to ensure that all residents are relocated to an appropriate setting. It is the responsibility of the county to ensure Adult Protective Services are involved in legal issues pertaining to their jurisdiction.

County responsibilities include the following:

- With the other members of the State Relocation Team, participate in the resident and family initial announcement, the resident and family relocation informational meetings, and the State Relocation Team orientation meetings. Inform the participants at these meetings about the ADRC and county programs and services, the role of the Managed Care Organization, IRIS, and the county in developing an individual community placement plan, financial options that may be available to assist in the relocation, and a county contact person.
- In waiver counties, affirm county of residence for identified facility residents, assign case manager(s), and complete assessments and Long Term Support (LTS) Functional Screens.
- Ensure that residents receive the information and support, including options counseling, necessary to make an informed decision/choice about community living alternatives.
- Ensure that care managers develop an Individualized Service Plan (ISP) for each resident to be relocated to the community. In concert with the resident/legal representative/family and other state relocation team members develop individualized placement/relocation plans. Submit the plans to the Department

for review and approval for services allowable under Home and Community-Based Waiver Programs.

- Recruit, identify or develop providers that can respond to each resident's individual needs. Make plans for any necessary training for direct care providers especially if restrictive measures are being contemplated.
- Develop and submit all needed requests for variances, for anything requiring a variance under the current Waiver Manual.
- If indicated, form required Team and Behavior Intervention Oversight committee. Then develop behavior intervention plans and restrictive measures application for any proposed use of restrictive measures.
- Assure that all residents' clinical needs, rights, financial and legal issues are being addressed while in the facility and when they relocate into the community.
- Be available to facility staff and residents, their legal representatives and/or families during the relocation process as outlined below:
 - Address concerns raised by facility and or residents, families, and legal representatives.
 - Provide technical assistance and training on disability and community services.
 - Develop recommendations for relocation alternatives.
- Attend Relocation Team meetings as a key member of the State Relocation Team, provide an update on planning progress to date and hear reports of relocation outcomes. Provide information to the team that will assist in developing an individualized placement plan for each county resident being relocated.
- Submit reports to the State Resident Relocation Team and other Department staff. These reports will include information on the following:
 - Up to date progress on community placement plans.
 - Available funding to support community services.
 - Progress on resource development.
 - Progress on securing Protective Placement or Guardianship if needed.
 - Issues or concerns which need to be addressed by the relocation team.

Role of the Aging and Disability Resource Center

Aging and Disability Resource Centers (ADRCs) are places where older people and people with disabilities can go for information, advice and help in accessing long term care programs and services. Basic services include information and assistance, options counseling, benefits counseling, and assistance with eligibility and enrollment in publicly funded long term care. Services are available to all members of the ADRC target

populations, regardless of the person's income or assets. Additional information on ADRCs is available at <http://dhs.wisconsin.gov/ltCare/Generalinfo/RCs.htm>.

The role of the ADRC in relocations is to offer residents, relocating from a facility that is downsizing or closing, the same services that it would make available to its other ADRC customers. Provision of those services may be expedited because of the timelines required for closure, but the nature of the services provided is essentially the same.

ADRC responsibilities during resident relocation:

- Receive notice of pending closure from the facility and the state relocation team lead.
- Participate in the initial meeting announcing the facility closure to facility residents, family members and legal representatives and briefly describe the ADRCs role in the relocation process.
- Participate in the informational meeting with residents, family members, and legal representatives to provide information on:
 - Service alternatives, funding options, and the eligibility criteria and process for accessing managed long term care, IRIS (Include, Respect, I Self Direct), and the fee for service system. Providing good information at this point in the process should help reduce the amount of time needed for options counseling later on.
 - The services of the ADRC and its role in the relocation process. Provide copies of the ADRC brochure and/or other written information describing the services of and contact information for the ADRC.
- Participate in initial state relocation team meetings. Participate in the subsequent relocation team meetings on an as needed basis.
- Serve as a resource to members of the state relocation team. Answer questions, provide written information, and provide other technical assistance where appropriate.
- Offer and, on request, provide options counseling to residents who are elderly and/or have physical or developmental disabilities. Options counseling helps people understand types of options available, the providers available in their community, the public funding programs and the eligibility process. [Note: The ADRC should review individual resident information from the relocation plan preparatory to providing options counseling.]
- Refer residents to the proper county agency to be assessed for the need for protective and placement and guardianship, when appropriate.

- Conduct LTC functional screens for residents who are seeking to enroll in Family Care, Family Care Partnership, or IRIS. When managed long term care is not yet available in an ADRC's service area and the person would be relocating under a Community Options Program (COP) or Community Integration Program (CIP) Waiver, the county human service agency is responsible for conducting the screen.
- Provide enrollment counseling and facilitate enrollment for those choosing Family Care, Family Care-Partnership, or IRIS.
- Expedite the options counseling, functional screen and enrollment counseling, and other enrollment related functions for relocating residents to ensure timely completion of the relocation process.
- Coordinate with other ADRCs involved in serving facility residents. In the event that a resident will be moving out of the area served by the ADRC where the facility is located, that ADRC is responsible for initiating coordination with the ADRC serving the area to which the resident is moving. In the event that a resident has been placed in the facility and continues to be the responsibility of a human service agency in another county, the ADRC where the facility is located is responsible for initiating coordination with the ADRC serving the resident's county of origin. All involved ADRCs are responsible for cooperating to best serve the resident being relocated.
- An ADRC may, at its discretion, elect to have staff travel out of its service area to serve county residents in out-of-county placements but is not required to do so. When necessary, information may be provided directly to a resident relocating from an out-of-area facility over the phone, electronically, by mail, or by coordinating with the ADRC serving the area where the facility is located.

ADRCs are not responsible for:

- Taking the place of the facility, state, or other players in the relocation process.
- Coordinating the relocation process.
- Taking the person to visit alternative placements. The facility is responsible for informing, planning, and arranging resident visits to alternate settings.
- Conducting assessments of the individuals to be relocated, beyond providing the functional screen.
- Developing relocation alternatives for individuals.
- Developing an individualized service plan or community service plan for persons being relocated.

- Arranging protective placement or guardianship for individuals unless the ADRC regularly performs these functions and is budgeted to do so.

Role of the Board on Aging and Long Term Care (Ombudsman Program)

The Ombudsman program works to protect the health, safety and welfare of long term care recipients and residents of residential long term care facilities. It is authorized by state and federal law to identify, investigate and resolve complaints made by or on behalf of residents and to mediate disputes relating to the long term care of the aged and disabled. It can represent the interests of residents before government agencies and seek administrative, legal and other remedies. The Ombudsman may, without notice, enter long term care facilities and have immediate access to a client or resident, and may communicate in private without restriction. It can access and review records with the consent of the resident or his/her guardian. More information is available on the Ombudsman Program at <http://longtermcare.wi.gov>.

The Ombudsman provides information and technical assistance to residents and clients about how to obtain needed services and advice and assistance in preparing and filing complaints, grievances and appeals.

The Ombudsman has the following responsibilities on the relocation team:

- Participate in the review of the Resident Relocation Plan, and as part of the State Relocation Team, assist in monitoring its implementation.
- Participate in and present information to residents and families at informational sessions and remain available to residents, families and facility staff during the relocation process.
- Provide information to residents and families, facilities and the relocation team regarding the following:
 - In-home and residential service options
 - Public funding to enable choices in living arrangements
 - Legal issues and client rights
 - Options for redress of concerns or complaints.
- Participate on the relocation team and monitor processes for resident/family involvement in adequate discharge orientation and planning activities. Represent the resident's interests and promote his/her choices.

- Participate, with authorization, in discharge planning conferences to advise and support the resident.
- Listen to concerns and advise in options for redress. Advocate, on the resident's behalf and propose possible solutions to resolve problems. Monitor to see that steps towards resolution are implemented. Assist in filing grievances and appeals.
- Assist in monitoring care and treatment at the facility. Consult on problems and suggest possible solutions. Confer with regulatory agencies.
- Participate and assist in organizing Resident and Family Councils.
- Follow up with some residents after having moved.

Role of Disability Rights Wisconsin Inc.

Disability Rights Wisconsin (DRW) is the Protection and Advocacy System for people with mental and physical disabilities in the State of Wisconsin. DRW is authorized under Chapter 50 as well as various other state and federal laws to receive information and advocate to protect the rights of people with disabilities. DRW participates as a member of the State Relocation Team both at the systemic and individual client level. More information is available at <http://www.drwi.org>.

DRW has the following responsibilities on the State Relocation Team:

- Participate on the Relocation Plan Review Team as part of the State Relocation Team when residents to be relocated are identified as having mental or physical disabilities.
- Be available to residents and families during the relocation process to provide technical assistance and information as needed, regarding the legal framework, requirements of discharge planning and community placement options for residents with disabilities in the relocation process.
- Provide advocacy services as agreed upon to individual residents with disabilities to assist them to assert their rights and preferences during discharge planning and help them obtain proper discharge planning and appropriate amounts of quality community services.
- Advocate within the team process to ensure that the facility, governmental agency or managed care organization meet the community long-term support or other disability-related needs of the residents.

Role of the Bureau of Long Term Support, Developmental Disabilities Services

DLTC Bureau of Long Term Support staff participates in the relocation process for individuals with intellectual disabilities by discharging their responsibilities associated with the administration of the CIP 1B Waiver and ICF-ID Restructuring. They work with county, Aging and Disability Resource Center (ADRC) staff and Managed Care Organizations (MCOs) over the course of the facility closing and resident relocation. Activities the section may facilitate include:

- Ensure and support County and ADRC and Managed Care Organization staff in the process of establishing good relations with individuals to be relocated and their families.
- Ensure that families and guardians know that state staff is part of the oversight process and may be contacted if counties, ADRC's or Managed Care Organizations are not responding to concerns and complaints.
- In waiver counties, the Community Integration Specialist (CIS) serves as a resource to the resident's county of residence, community providers, and residents and families/guardians during the relocation process as outlined below:
 - Provides assistance in service plan and/or resource development to the County staff and to facility discharge planners.
 - Coordinates with county staff to ensure that counties provide residents/guardians information about choices and opportunities for community living in order for them to make informed decisions about community alternatives.
 - Provides information, as requested during initial meetings and as needed thereafter, to residents, family members, guardians, and facility staff regarding funding limitations, eligibility criteria, and service alternatives.
 - Provides information to the State Resident Relocation Team about what a county has done or is doing in terms of planning and status information about the person's plan.
 - Reviews and approves county individualized service plans. This includes any special approval processes required, such as variances and restrictive measures approval.

Role of the Managed Care Organization (MCO)

The role of the MCO is to work with residents, who are enrolled or who proceed to enroll in Family Care or Family Care Partnership or Pace (Programs of All Inclusive Care for the Elderly) to arrange their relocation to a community-based setting or to another nursing home. It is then the responsibility of the MCO care management team to work with the resident to achieve an alternate placement. Additional information is available on MCOs at <http://dhs.wi.gov/ltcare/Generalinfo/CMOs.htm>.

The MCO(s) may be invited to attend the Resident and Family Announcement and Informational Meetings. The MCO(s) will explain their role in the relocation of residents and the potential services they offer to members with emphasis on the possibility of an appropriate community placement.

MCOs accept referrals/enrollees for relocation planning from ADRCs and from the relocation team. Residents not already enrolled in a Medicaid long term care program must receive options counseling from the Aging and Disability Resource Center (ADRC). If more than one MCO or more than one Family Care program is available (Family Care or Family Care Partnership) or PACE, the resident will choose his/her MCO during the ADRC options counseling and enrollment process.

Once enrolled, the MCO will gather the information needed to develop a relocation plan for the resident, identifying the individual's desired personal experience outcomes, so that the relocation plan can provide the supports needed to achieve the resident's preferred outcomes. These personal outcomes are determined using the Resource Allocation Decision (RAD) method. Relocation planning includes the resident and/or his/her legal representatives as well as other informal supports identified by the resident which may include family and friends.

For relocations of residents from Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF-ID), who enroll in a managed care program, MCO staffs communicate with their Member Care Quality Specialist (MCQS) from the DHS Office of Family Care Expansion who will need to approve the resident's relocation plan as being cost effective. MCOs must also make sure a restrictive measures plan is developed and approved, if applicable to the particular relocation.

If the resident's relocation planning occurs prior to their Family Care enrollment date, the necessary releases for obtaining confidential information are obtained from the individual during the ADRC options and enrollment counseling process. Usually the enrollment date is the date of discharge from the facility. Aging and Disability Resource Centers determine the resident's enrollment date.

Role of IRIS (Include, Respect, I Self-Direct)

IRIS is a self-directed supports waiver program. A participant of the program self directs his/her publicly funded, community based, long term care supports and services. A potential participant contacts the local Aging and Disability Resource Center (ADRC) regarding eligibility. The ADRC will describe how the program works and explore with the resident/family/legal representative the services available under the program. If the resident makes the decision to participate in the program, an Independent Consultant supports the resident in developing a plan and provides more detailed information about IRIS. <http://dhs.wi.gov/bdds/IRIS/index.htm>

The Independent Consultant provides for feedback to the State Relocation Team on the status of the resident's relocation plan. Problems/barriers hindering the execution of the plan would be explored and solutions sought by the relocation team. An IRIS ombudsman is available through Disability Rights Wisconsin or the Board on Aging and Long Term Care.

Role of the Division of Quality Assurance

The responsibilities of the Division of Quality Assurance (DQA) include the following:

- Regulate and monitor residential facilities' compliance with federal and state law and the rules and regulations that apply to residential facilities during the closure or down-sizing and resident relocation period.
- Manage the licensure of residential facilities including the surrender of licensed beds from closing residential facilities as well as the licensing of new residential facility beds when capacity building occurs.
- Investigate complaints against health care facilities. Complaints may be regarding day to day operations of either the sending or receiving facilities, and/or to the resident relocation process itself.
- Attend the initial notification meetings with residents, families, interested parties, and facility staff when the facility announces its intent to close or down-size. DQA attends on an "as needed" basis.
- Advise and assist the Resident Relocation Team as requested on a case by case basis.
- Remain informed and current regarding the status of the closing or down-sizing facility and the relocation of its residents through frequent contact with the Division of Long Term Care State Relocation Team Lead.

Role of the Division of Mental Health and Substance Abuse Services (DMHSAS)

The role of Division of Mental Health and Substance Abuse Services includes the following:

- For nursing homes, DMHSAS staff cross-references the list of residents to be relocated to the Preadmission Screening and Resident Review (PASRR) database. The PASRR process is based on federal law and requires the state to determine the following: if persons who have a mental illness or developmental disability need nursing facility placement, and/or if these persons need specialized services to increase independent functioning that currently is limited, due to the mental illness or developmental disability.
- Reinforces that persons who are determined through the PASARR 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. DMHSAS encourages and assists county participation in the relocation of persons with mental illness from the facility to a community placement or from one nursing home to another nursing home.

Role of Area Administration – Division of Enterprise Services

The Human Services Area Coordinator (HSAC) from the DHS Regional Office of the Division of Enterprise Services has a supportive role in facility closures.

- Encourage county, ADRC and MCO participation in the process of assessment and screening of residents for possible community relocation.
- Facilitate joint planning and sharing of resources when more than one county is involved with the relocation process.
- Identify regional need for technical assistance and training.
- Resolve any residency disputes, inter-county or inter-state transfers or venue changes.
- Act as a liaison between the state relocation team and the non-primary counties involved in relocating residents for whom the counties have legal or financial responsibilities.

Section V

Ongoing Relocation Process Resident Relocation Team Relocation Meetings

Relocation Team Meetings

Initial Orientation Meeting For State Relocation Team Members

Purpose

The purpose of the initial relocation team orientation meeting is to introduce the state relocation team members to each other and set the stage for a successful relocation process. This meeting provides each team member an opportunity to clearly articulate its role and scope of responsibility.

Additional purposes of the orientation meeting include:

- To introduce the members of the relocation team and discuss team roles.
- To inform all relocation team members, including those of the facility, of any aspects of the resident relocation planning process about which they may have questions.
- To discuss rights of residents, including the right to options counseling and the least restrictive/most integrated alternate setting, legal issues, the mitigation of relocation stress syndrome/transfer trauma and other areas of the relocation process needing clarification.
- To afford facility staff the opportunity to ask questions regarding their newly assumed role in the relocation process.
- To afford facility staff the opportunity to articulate their role in providing care and services to residents as it impacts the relocation process.
- To afford the facility administrator the opportunity to update the State Relocation Team on the current operational and closure status as it relates to available resources and potential barriers.
- To provide all relocation team members an understanding of how the relocation team works together in assisting the resident to achieve the appropriate relocation setting of their choice.
- To discuss the role of MCOs, IRIS, and county waiver programs and how they impact the role of the State Relocation Team.

Participants

Key participants are the members of the State Relocation Team. The relocation team lead will discuss the purpose and establish a time for the meeting with facility representatives including the facility relocation coordinator. The advocacy team members will be represented depending on the characteristics of the residents, i.e. over 60 years, less than 60 years, disabilities. The county will be represented by staff from the ADRC or from county waiver programs.

Timing

The initial team orientation meeting with facility staff and the other relocation team members can be scheduled on the day of the initial announcement of closure meeting or at the time of the informational meeting. However, it is recommended that adequate time for the meeting be allocated.

Initial Resident Relocation Meeting

The initial relocation team meeting will be scheduled by the State Relocation Team lead. This meeting is conducted and facilitated by the state team lead. The lead provides the agenda, coordinates the communication protocols, and maintains the relocation team contact list.

The facility will set the tone for a professional meeting by providing a space/room which is conducive to confidential discussion of protected resident health information. All team members should allocate sufficient time for this initial meeting as the purpose is both an in depth review of resident data as well as providing opportunities to inform and educate team members.

The expected outcomes of the initial relocation team meeting are the following:

- Further introduction of relocation team members and any further necessary discussion of team roles and responsibilities.
- Establish meeting protocols and agenda development.
- Determine frequency, date, and times of meetings.
- Determine attendance and participation of resident relocation team members according to role and as defined by the client characteristics, resident preference for living arrangement, and any special circumstances impacting decision making.
- Confirm assignments of team members to ensure follow through.
- Confirm that all resident clinical and financial information, including applications for SSI, is available and that the information will be updated on a regular basis
- Conduct a resident by resident clarification of all data provided.
- Determine the future format for resident review.
- Determine resident current membership in MCOs, relevant insurance plans and the need to establish liaison relationships with them to expedite the resident relocation process.
- Determine timelines/initial contact process for ADRCs and county waiver programs to initiate options counseling for residents.

Ongoing Relocation Meetings

The ongoing resident relocation meetings are conducted and facilitated by the state resident relocation team lead who distributes the agenda, ensures appropriate distribution of the updated resident roster and coordinates additional resources as needed.

The expected outcomes of the ongoing relocation team meetings are as follows:

- Meet at least weekly at the facility/via teleconference, or as often as the state relocation team determines.
- Review the status of each resident's relocation plan including resident relocation planning meeting.
- Assist in identifying the residents' potential options for living arrangements.
- Sets goal dates for completion of required assessments, resident and legal decision making contacts, confirmation of financial status, guardianship status/updates, PASRR screening updates, etc.
- Review resident status with regard to contact with the ADRC, options counseling, enrollment in MCOs, IRIS and Medicaid fee for service etc.
- Review status of resident relocation planning, including options counseling and relocation planning occurring under county waiver programs.
- Identify barriers, if any, to achieving the resident's choice of living arrangement.
- Strategize plans for resolution of any barriers to relocations.
- Review with the appropriate MCQS the relocation status of currently enrolled members/residents and newly enrolled members/residents.
- Review the status of each resident's discharge planning meeting when the choice of an alternate placement has been made.
- Review and coordinate with resident entities such as insurance plans their role in the resident relocation and the status of the resident.
- Review possible or actual resident change of condition from their initial status on the Resident Roster.
- Review facility provision of updates on operational status and any potential impact on relocation.
- Discuss potential room/unit consolidation due to relocation.
- Resolve conflicts regarding agency scope of responsibility as it relates to individual residents.
- Assure security of resident protected health information as it pertains to relocation activity.

Section VI

Ongoing Relocation Process Closing Facility Receiving Facility/Entity Community Service Providers

Ongoing Relocation Process – Receiving Facility

Nursing Home, ICF-ID, or CBRF/Assisted Living

Roles and Responsibilities of Key Facility Leadership

The relocating residents will need special care and attention. The residents' need to relocate from a facility many have considered their home is a cause of relocation stress syndrome/transfer trauma for almost all involved residents. The relocation process is particularly traumatic for residents with cognitive impairments. The receiving facility/alternate living setting plays a key role in the successful relocation of the residents.

While the entire closure and relocation process is a challenge to all involved, including the receiving facilities, it is also an opportunity to make a significant impact on the quality of life for the residents who have chosen to be entrusted to their care. In assisted living facilities staff may not carry the same titles or responsibilities discussed below. However the majority of the discussed responsibilities will be applicable to various responsible staff members in assisted living facilities.

Administrator

The receiving nursing home, Intermediate Care Facility for Persons with Intellectual Disabilities (ICF-ID) or assisted living facility administrator needs to determine its capacity to provide alternate placement for residents going through the relocation process. Admission screening staff will need clear directions regarding the number of residents/clients that can be admitted to the facility in a specific time period.

The administrator's relocation responsibilities include:

- If indicated, coordinating and notifying of the intent to be a facility accepting relocating residents.
- Maintaining a resident centered leadership style.
- Providing the resources necessary for complete pre admission and post admission assessments and delivery of needed care.
- Ensuring that the physical transfer of belongings and financial accounts has been completed and that the resident is satisfied that all belongings and funds have been accounted for and transferred.
- Receiving all necessary, accurate and current resident clinical information from the closing facility.
- Upon request communicating with the State Relocation Team to provide updates on the progress of relocated residents.
- Making provision for training for all staff on transfer trauma/relocation stress syndrome (RSS) to mitigate the potential negative effects the relocation may have on admitted residents. SEE Section VII for RSS training resources.

- Maintaining effective communication with MCOs and county waiver program case managers.

Director of Nursing/Responsible Staff Person

The receiving facility Director of Nursing/responsible staff person will ensure that the facility has needed resources to give appropriate care to residents accepted from the closing facility.

The Director of Nursing/responsible staff person responsibilities may include:

- Maintaining a resident centered leadership style.
- Coordinating resident clinical care and services.
- Educating staff and coordinating physician involvement in the identification and treatment of relocation stress syndrome. See Section VII.
- Assisting with the pre admission and post assessment process including facilitating the exchange of appropriate resident specific information including the client plans developed by MCOs/county waiver programs.
- Ensuring the clinical records received from the relocating facility are current and contain the information needed to provide appropriate care to the resident.
- Maintaining effective communication with MCOs and county case managers.
- Addressing resident, family and staff concerns related to the resident admission process.
- Being responsible for the care delivered to residents as it relates to the admission/relocation process for the newly relocated residents.
- Providing the resources necessary for the appropriate care of the relocated residents.
- Ensuring direct care givers have the information necessary to maintain, to the extent possible, resident routines and are familiar with resident preferences and dislikes and other parameters of the resident's care such as ambulation distances.
- Monitoring for signs and symptoms of relocation stress syndrome.
- Coordinating with ancillary services/MCOs/county waiver programs to ensure necessary medical supplies/supports are available at the time of admission.
- Ensuring there is an accurate inventory of all resident possessions.
- Maintaining confidentiality of all protected health information (PHI).
- Serving as a contact to the state resident relocation team to provide updated resident clinical data relative to the effects on the resident of the relocation process.

Social Services/Admissions

The receiving facility social services staff/responsible staff person will provide psycho/social support and services to meet the new resident's needs and to meet state and federal requirements relating to the preadmission screening process, active treatment and related treatment recommendations. The social services staff person will advocate for the

residents and communicate with the facility administrator any concerns and grievances relating to the relocation process.

The facility social services/admissions staff is responsible to:

- Facilitate communication with the closing facility, resident and/or their legal representative and MCOs or county waiver program staff.
- Facilitate residents/family/legal representative pre admission tours of the facility.
- Identify special needs of residents that must be considered prior to and at the time of relocation and convey this information to the staff.
- Identify the resident decision making status and confirm/assure a legal decision maker is in place prior to admission.
- Facilitate the validation of the legal decision maker.
- Provide residents with the opportunity to communicate with advocates.
- Document all aspects of the admission process including the preadmission assessment process.
- Serve as a contact to the state resident relocation team to provide updated resident clinical data relative to the effects on the resident of the relocation process and the occurrence of any signs and symptoms of resident relocation stress syndrome.

Financial – Business Office Manager/Responsible Staff Person

The Business Office Manager or responsible staff person will be responsible for the security of resident funds, accounts and financial information throughout the admission process.

The facility business office manager/responsible staff person will be responsible for:

- Conducting an initial accounting of all funds and accounts upon admission.
- Assisting in the transfer of financial information from the receiving facility.
- Confirming that the change of address process for each resident has occurred or assist in the process.
- Notifying Social Security, Medicare and Medicaid and other payer sources as indicated.
- Maintaining accurate financial records and monitoring personal accounts of residents.

Ongoing Relocation Process – Community Service Providers

Supervised/Independent Apartments, Staffed Room & Board Facilities, Private Care Givers, Care Workers, Managed Care Organizations/IRIS/County Waiver Programs, Other Community Service Providers

Residents relocating from a closing facility may choose an alternate living setting that is not a licensed, certified, or registered facility. A variety of options are available in the community.

Many of these residents will require community services to obtain the supports necessary for maintaining their independence. Some residents may choose to return to their own home or the home of a relative or friend. Some may choose to go to supervised or independent apartments. Some residents will be appropriate for room and board facilities where there are staff members present all or parts of the day. Many will benefit from day programs. Some residents will require services from home health agencies or personal care providers. Often residents will have case managers from their managed care organization (MCO) or county waiver program who are assisting them to succeed in the more independent settings.

While the stress/trauma of relocating to other facilities is well documented in the literature, the presence of relocation stress syndrome/transfer trauma is not as well addressed for residents relocating to more independent community settings such as those described above. This manual provides relocation stress syndrome (RSS)/transfer trauma resources for community providers. See Section VII for RSS resource information specific to community relocations.

During follow up visits to relocated residents and Relocation Team “lessons learned” evaluations of the resident relocation process, the Department and its relocation teams have learned that relocation to more independent settings can be difficult if appropriate preparations and supportive services are not put in place in a timely manner.

In nursing homes, ICFs-IDs, and CBRFs residents live in protected environments where most of their daily needs are met. The physical environment is often highly structured and controlled. Their need to make important day to day decisions is reduced. Relocation to the community can, initially, be a cause of much anxiety to the resident. This dynamic must be considered by the community service system including MCOs, IRIS, county waiver programs, and other entities serving these residents.

Community service system providers may not be familiar with this manual. Facility staff members have a great deal of contact with community providers during the discharge planning process for each resident. During this time facilities should direct community providers to the Relocation Stress Syndrome resources in this manual, giving them copies of the materials and/or directing them to the web site. Relocation team members may also contact community providers to familiarize and update them on the effects of

Relocation Stress Syndrome. The Resident Relocation Manual address on the Department website is http://dhs.wisconsin.gov/rl_dsl/Providers/relocation.htm.

Guide for Receiving Facilities/Entities

For receiving facilities/entities, the goal is to focus on the relocated resident and her/his needs and wishes in order to mitigate or minimize transfer trauma/relocation stress syndrome after relocation.

The points below directly apply to all facilities and entities. Most of these points can be adapted and become applicable in providing services/care for the residents/clients who are relocated to more independent community settings. The following actions will assist the resident in adjusting to his/her new living setting/home.

- Know that a resident who is relocating may be experiencing emotional and physical symptoms related to relocation stress syndrome/transfer trauma.
- Facilitate a caregiver to visit the resident in the closing facility in an effort to ease the resident's transition to their new home.
- Facilitate a resident tour of the facility/living setting before the actual day of the relocation.
- Designate a primary facility contact for the resident/family/legal representative to keep in contact with throughout the relocation process and after the actual relocation.
- Provide names and contact information to resident/family/legal representative for key staff in the receiving facility.
- Assure nursing staff and other interdisciplinary team members/service providers review transfer information (physician's orders, medical history, social history, etc.) and complete admission assessments. The team needs to assess the resident's risk for relocation stress syndrome/transfer trauma. Include the resident/family/legal representative's input in the assessment process.
- Seek out resident information regarding likes, dislikes, preferred daily routines, etc. and ensure the information becomes part of the direct care givers' care plan.
- Contact transferring facility to clarify transfer information as needed.
- Implement admission care plan addressing potential risk for transfer trauma/relocation stress syndrome and interventions to minimize risks.
- Document resident's reactions and concerns upon arrival.

- Be alert for and put interventions in place to address safety risks such as weight loss, falls, anxiety, and confusion that could result from being in an unfamiliar environment.
- Provide a warm, friendly environment and encourage family/legal representative to stay while the resident is getting settled in his/her new living setting/home.
- Review the personal belongings inventory, from the closing facility, and verify the presence of all belongings and any funds.
- Assist resident to unpack and organize belongings with resident input.
- Introduce new resident to the other residents, volunteers, staff, and families as the resident is willing.
- Establish routines for the resident with resident and family/guardian input and with information shared from the closing facility.
- Assign a primary nurse or caregiver to assess the resident frequently and to monitor for signs of transfer trauma/relocation stress syndrome and implement necessary interventions.
- Assign a consistent caregiver(s) for at least the first 30 days to assist the resident with transition to their new environment.
- If indicated, encourage attendance and participation at resident and family councils.

Section VII

Resource Materials Relocation Stress Syndrome Transfer Trauma

Introduction Relocation Stress Syndrome/Transfer Trauma

Relocation Stress Syndrome/Transfer Trauma (RSS/TT) may be defined as the physiologic and/or psychosocial disturbances that may result for a resident during the process of relocation from one environment to another.

The signs and symptoms of RSS/TT can display themselves in a variety of ways including depression, anger, withdrawal, weight change, and falls. Enclosed in this section of the Manual are tools to assist both discharging and receiving facilities and community service providers in their efforts to prevent RSS/TT.

The staff of the closing and receiving facility/community service providers, attending physician, designated decision maker, in collaboration with the State Resident Relocation Team must make every effort to mitigate the effects of relocation stress syndrome on the resident. It is the responsibility of designated staff of the closing facility to develop an organizational plan to identify, implement interventions, educate, inform receiving facilities/community service providers and monitor the potential signs and symptoms of relocation stress syndrome.

It is recommended that the tools provided in this section be given to all receiving facilities/community service providers as part of the transfer documentation. Receiving community service providers would include, but not be limited to, case managers, home health agencies, supervised apartments and transitional housing.

Information, for Discharging and Receiving Facilities, for Inclusion in Staff In-Service on Resident Relocation Stress Syndrome Transfer Trauma

Chapter 50: governs the closure of nursing homes and community based residential facilities with the primary focus being on the resident who is being relocated from their home, the closing facility, to an appropriate placement/setting of their choice.

50.03(14) states “the department may provide, direct or arrange for relocation planning, placement and implementation services in order to minimize the trauma associated with the relocation of residents and to ensure the orderly relocation of residents.”

Chapter 50 provides for a relocation team to facilitate the relocation of residents from closing facilities. The state relocation team consists of the facility, the county, which may be represented by staff from the Aging and Disability Resource Centers (ADRC) or the county waiver programs and other involved units, the advocacy agencies (the ombudsman from the Board on Aging and Long Term Care and staff from Disability Rights Wisconsin), and the Department of Health Services, Division of Long Term Support.

The process emphasizes the need to address and mitigate the effects of RSS.

Relocation Stress Syndrome/Transfer Trauma

The terms Relocation Stress Syndrome (RSS) and Transfer Trauma (TT) are used interchangeably when discussing the emotions and psychological impact experienced by a resident who is forced to relocate due to closure of the facility where they reside.

Relocation Stress Syndrome is defined as “Physiologic and/or psychosocial disturbances as a result of transfer from one environment to another.” (NANDA International formerly North American Nursing Diagnostic Association, 1992)

It is otherwise defined as “the combination of medical and psychological reactions to abrupt physical transfer that may increase the risk of grave illness or death.” (“Role of the Ombudsman in Nursing Home Closure”)

Characteristics of RSS

Five resident/patient characteristics that may occur with RSS/TT are:

- Dependency.
- Confusion.
- Anxiety.
- Depression.
- Withdrawal.

Facility Experience With RSS

Facilities already have extensive experience dealing with persons suffering relocation stress syndrome. The facility deals with RSS with almost every resident who has been admitted. Very few residents welcome the relocation from their home environment. The resident experienced their original episode of RSS when they went from home or hospital to the nursing home or community based residential facility (CBRF). They may well have also experienced RSS when and if first admitted to the hospital and on subsequent admissions.

RSS and Facility Closure

What differentiates resident relocation stress from the stress residents suffer when admitted to a nursing home/CBRF from their home?

The residents who are relocated from a nursing home/CBRF have already endured the trauma of their initial admission from their own home to a facility that the vast majority viewed as becoming their permanent residence until their death. They are now forced to contemplate relocating from this familiar facility to an unknown setting. Some residents may view this new relocation as aiding their desire to move out of their current residence. Indeed relocation for some residents means relocation to a less restrictive setting.

Information gained from resident and representative feedback indicates the major portion of residents view the initial disclosure of the need for relocation as a shocking and frightening development. Almost all residents have at least an initial sense of loss of control and predictability in their lives.

Facility Announcement/Action

What actions should be taken when residents are informed they must leave the facility that is functioning as their home? The resident needs the support of individuals who they feel will assist them in this traumatic/stressful time

It is important that residents are reassured that they will not be moved until they have a choice regarding where they will be relocated. A calming atmosphere is important. Still, emotions described by residents who have had follow up visits include the ones described below.

“Shock, I cried, would any body want me, where would I go and would my visitors still be able to visit me.” Residents also verbalized not wanting the facility to close. “I didn’t want to move, staff were crying and upset.”

At one announcement of facility closure, a resident was observed anxiously saying “do I have to find my own place to live? Does my family know I have to move?” A resident at another facility questioned the need to move saying this is the “Best place I ever lived!” Other residents have simply stated they would rather die than move. Some residents may not be able to verbalize their emotions but experience changes in behavior in reactions to experiencing changes in their environment, caregivers, and routine.

Staff has just received the news of the facility closing. They are dealing with the trauma of knowing they may or will soon lose their jobs and their relationships with residents and coworkers. At the same time, they are usually the same persons who will answer resident questions and try to comfort them. How is staff able to support the residents?

(Staff should receive relocation stress syndrome training as soon as possible.)

Staff is having some of the same reactions as the residents. Staff needs to recognize their own reactions to news of closure and how it affects their reaction to residents with RSS.

Staff needs to recognize signs and symptoms of resident RSS and appropriate interventions have to be identified and initiated for the individual residents. Staff should receive relocation stress syndrome training as soon as possible.

Resident Reactions to Closure Announcement/Relocation

What are some of the changes in residents that may be seen both after the relocation announcement and after relocation? The changes affect all residents. The changes affect those who are not cognitively impaired and those who are cognitively impaired.

What observations is staff making regarding resident reactions and also those of families?

Behavior Characteristics of the Resident that appear to be either new or changed may include the following:

Expressions of anger/irritability.

Expressions of depression/sadness.

Expressions of anxiety/apprehension.

Withdrawal, social isolation, not going to activities or the dining room. Note the importance of knowing resident's prior preferences.

Verbalization of insecurity, dependency, increased need for reassurance.

Verbalization of a lack of trust.

Wandering, sun downing.

*Exhibiting increases in combative behaviors, hostility, belligerence, intrusiveness toward others.

*Always physical changes must be considered when evaluating behavior changes. Among changes in health status that the resident may be experiencing that influence behavior are urinary tract infections or transient ischemic attacks.

Residents Who Are Cognitively Impaired – Strategies

The term cognitive impairment is very inclusive. It will include persons with Alzheimer's Dementia, traumatic brain injury and intellectual disabilities. The evidence of cognitive impairment will be reflected in varying degrees. Some individuals will be able to be interviewed and will reflect on the relocation experience. Other individuals will appear to have no response to the relocation process. This number is very low and these are the residents who may demonstrate behavioral changes both before and after relocations as their environments, caregivers, and care routines change.

Almost all residents will realize that their life is changing as appropriate placements are sought and their known environment starts to change. Familiar residents will begin to be relocated from the facility and may include the residents' roommates and friends.

The interdisciplinary staff needs to care plan the events leading up to the relocation and the actual relocation of each resident.

The resident needs to be assessed for the perhaps more subtle changes of RSS. Is their appetite decreasing? Are they sleeping less? Are they refusing cares and known routines?

If behavioral changes occur they need to be documented, assessed and care planned. The receiving facility needs to be aware of what the resident's normal behavior is in order to be able to identify a change in behavior.

The care routine needs to be explicitly documented to allow as much continuity as possible. The resident may have difficulty communicating their status including changes and needs.

An attempt to assign staff familiar with cares is important. This is important for both the closing and receiving facility. The receiving facility may hire staff from the closing facility. These staff may be already familiar with the resident, their routines and care.

The resident should have the fact they are relocating explained to them. It may not be possible to determine the extent they are able to benefit from the explanation. However, the possible inability to quickly determine their level of understanding of the closure and relocation should not deter reasonable

explanations from being given. The explanation and reassurance may need to be repeated many times.

The cognitively impaired resident may well be able to tour the potential relocation facility/setting and see/evaluate the setting where they may be relocated. This will aid them in choosing their new facility. Meeting new staff may help with their anxiety. The tours should be conducted if at all feasible. The resident has the same right to tour as residents who are not cognitively impaired. Again the possible inability to quickly determine if the resident is benefiting from a facility tour should not deter the resident from touring a potential relocation placement if it is at all feasible.

Relocation Strategies for All Residents

The resident is the primary decision maker in their relocation. They need to be included in all aspects. The selection of an alternate setting is ultimately their choice. Residents will rely heavily on family members, case workers and other representatives to facilitate their relocation. The more control they exercise the more they will be accepting of their relocation.

The resident may want to consider moving to an alternate placement where other residents are relocating and/or may wish to have another resident as a roommate in their relocation setting.

The resident needs to tour any potential alternate settings and exercise choice in deciding on a living environment/arrangement.

Receiving facility staff should visit the closing facility and the perspective resident for the purpose of assessing the resident in their environment. It is important to discuss the resident and their needs with the closing facility staff.

Closing facility staff should accompany the resident when the actual relocation takes place. It is important that the resident's new physical environment be set up to reflect their preferences and how it appeared and functioned at the closing facility.

Closing facility staff should, if at all feasible, go onsite to review the care routines of the resident with staff who will actually provide the care. It is

very important that nurse aide care plans are up to date, very specific and transferred with the resident.

It is important to document resident preferences and the aspects of their personality that contribute to their personal uniqueness. Closing facility staff should review resident needs and preferences with the new facility. Many residents can't or won't express their preferences.

Resident records need to be up to date and reflect the resident's physical and emotional status including their reaction to the need to relocate. These records will allow the receiving facility to identify any changes in resident condition and accurately assess their current status.

Characteristics of Resident Relocation Stress Syndrome

Observed Changes at the New Facility for All Residents

Upon relocation to the new facility, the resident may experience both physical and emotional changes. It is important that the receiving facility has the information that allows them to assess these changes in condition and to consider if they represent either a continuation or a new manifestation of RSS. Some of the observed changes that may be the manifestation of the characteristics of RSS include the following items:

Decrease in appetite, weight loss – very significant, transfer of appropriate information is essential. Was the resident losing weight before their relocation? Did they have feeding precautions/instructions in place? Is the resident being fed with proper positioning? Do the residents have food preferences?

Signs of dehydration – how does the resident usually handle taking in fluids? Does the resident need to have their intake and output measured at least initially?

Decrease in ability to perform activities of daily living (ADL):

- Bathing
- Dressing
- Eating
- Mobility

- Toileting
- Change in continence status

Occurrence/increase in falls.

Change in sleeping habits.

Withdrawal from organized activities.

Loss of strength and endurance. (During a follow up visit, it was learned one resident experienced a very real loss of strength and attributed it to the car ride to the new facility, a distance of 22 miles. It was apparent the actual act of relocating was very stressful, including physically, for this resident.)

Resident Verbalizations at the New Facility

A resident who has been relocated may verbalize signs of relocation stress syndrome such as the following:

Not wanting to leave the original facility.

Comparing staff of the two facilities with the new staff being viewed unfavorably compared to the former staff.

Calling staff from the former facility.

Conveying feelings of lack of control over the environment/lack of predictability.

Conveying a sense of loss regarding the inability to continue to smoke or use smokeless tobacco products.

Expressing concern over finances, new facility may cost more.

Expressing concern over family and friends ability to visit due to location change.

There may be a verbalization of a positive attitude toward the new facility.

There may be a verbalization of liking the new facility better.

Mitigating the Potential for Relocation Stress Syndrome Closing Facility and Receiving Facilities/Entities

Recognize that the resident, will to varying degrees, experience transfer trauma/relocation stress syndrome. The majority of the time, the resident is relocating because they are being discharged on an involuntary basis. Again, the relocation may be in the same city or town or 50 plus miles away. No matter how far it is geographically, the relocation is a tremendous change for the resident to assimilate.

The size of the new facility/entity may be different. It is helpful for the resident to tour so they are not shocked at differences in size when they arrive at their alternate setting. If they are not able to tour, pictures may help them prepare for change in their environment.

Meeting staff from the new facility/entity before the relocation and being made to feel welcome will hopefully decrease some of the stress over the relocation.

The receiving facility/entity should conduct staff in service on RSS and the strategies to mitigate any relocation stress/transfer trauma the relocating resident may be experiencing.

The discharging facility must provide all the information necessary to know the resident. This includes the medical, nursing and social information. Important transferring information includes that which contributes to the uniqueness of the person, including their specific likes, dislikes, and characteristics.

The receiving facility/entity needs to review all the transfer information that accompanies the resident. The new staff needs to know the resident, to the extent possible, in order to plan quality/adequate care for the resident.

The receiving facility/entity needs to have verbal contact with the closing facility. Staff must know who at the discharging facility is to be contacted for follow up information and consultation regarding the resident.

Receiving facility/entity staff must know who the resident's physician is and if the resident is new to the physician. Staff needs to ascertain what resident

information has been released to the physician. It is important to know if the physician, if new, has had contact with the discharging facility and have they received necessary records from the closing facility.

Receiving facility/entity staff needs to evaluate any variances between the resident's physical and emotional status and relocation reactions that have been separately assessed by the discharging and receiving facility/entity. The care plan may need to be revised. In order to authenticate any apparent changes, staff may need to discuss them with the discharging facility. The staff may need to contact the physician. The stress of the actual physical relocation may signal rapid change in resident status.

The admission assessment should have documented the resident's reactions (emotional, behavioral, cognitive and physical) to the relocation. All relocation issues should be noted on the Initial Plan of Care. The plan of care should indicate that the resident has relocated from another nursing home or CBRF and is experiencing or may experience RSS. The new facility/entity must pay special attention to safety related issues. The new environment is strange and it will take time for the resident to adapt.

The receiving facility/entity should provide the resident with a routine as similar as possible to the previous routine, if the previous routine was in agreement with the resident and is the current needed routine.

Telephone numbers of direct care staff of the discharging facility/entity and the receiving one should be exchanged to expedite the communication for questions and care issues that arise after relocation.

The transferring information needs to be inclusive so the new facility/entity knows the resident parameters in order to establish if base line changes in behavior and physical condition are occurring.

*Note: Some residents will actually prefer the new facility or setting to their former facility. They will be very happy with the relocation and may show physical and mental improvement. The resident may relocate to a less restrictive environment and/or they may be closer to family/visitors. They may simply benefit from a "change."

Resident Transition on the Day of Relocation – Receiving Entity

It may be emotionally devastating for the resident to physically leave the closing nursing home or CBRF.

The resident may arrive at the receiving facility/entity feeling distraught and/or confused and afraid. Strategies to benefit the resident include the following points:

- Provide a sensitive and warm welcome to the resident.
- Encourage family and other visitors, if present, to stay while the resident settles in.
- Have an assigned staff person to support the resident on the first day of their relocation and thereafter as needed.
- Identify the staff person who the resident and/or family or another representative is to contact with concerns. This identification coupled with a response will help solve problems before they occur. The family is stressed by the need to relocate their family member. They are also unsure of their acceptance in the new facility/setting. They may verbalize many concerns about the care or they may be fearful of saying anything that could be construed as negative. It is important to have the resident and their representatives on board as part of the care team. The receiving facility/entity needs to help them find comfort in the acceptance of this role.

Resident Follow Up After Relocation

Resident follow up after relocation is essential to determine the effectiveness of the relocation process for residents. The follow up is a key step in determining if reasonable steps have been taken on a consistent basis to mitigate the effects of transfer trauma/relocation stress syndrome on relocating residents. In addition, information gathered during the follow up process provides valuable insights into improving future relocation efforts.

All of the relocation team members have a needed role in following up on the residents after they have been relocated to an appropriate setting of their choice.

As indicated, the discharging facility will follow up on some of the residents during the relocation process. The facility staff should be available to serve as a resource for new caregivers and other service providers.

The advocates will follow up to ensure resident rights are being observed and to determine the appropriateness of the relocation and ways to improve the process.

The county waiver programs/Managed Care Organizations (MCO) will have continued involvement with residents who choose to live in the community or are members of the MCO and continue to reside in a nursing home.

As indicated, the Department may follow up with both residents and families and other service providers. The Department will follow up with the closing facility to the extent needed and possible.

The goal for all involved in the resident relocation process is to mitigate the effects of relocation stress syndrome/transfer trauma. This goal naturally evolves to the constant striving to improve the resident relocation process.

Note: Copies of the Board on Aging and Long Term (BOALTC) resources “Awareness: Relocation Stress Syndrome” and the “Discharge Planning Guide” are part of the technical assistance offered both the receiving and discharging facilities by the Ombudsman from BOALTC. These brochures may be obtained at the BOALTC website <http://longtermcare.wi.gov>

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Strategies to Assist In the Mitigation of Staff Relocation Stress Syndrome

Staff Relocation Stress Syndrome – Closure Announcement

When the facility closure 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 or the closure announcement may be a total shock to some or all of the employees. The facility needs to be aware of the effect the closure announcement will have on staff well being and the potential impact on staff job performance.

Staff Reaction

The staff will suffer the effects of relocation stress syndrome (RSS). They have not made a decision 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 a period of time, the staff realizes 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 over the facility closure. They will have to assist the residents in preparing for relocation to a new living environment. The time to actively grieve their loss will be very limited.

The residents are being forced to leave their familiar surroundings, staff, other residents and friends. They are leaving a facility they may consider to be “home.” The staff is experiencing a parallel scenario to the residents’ reactions. How can staff cope with their own RSS and simultaneously assist the resident in coping with their RSS? This is the challenge presenting to the closing facility. It is a challenge for a facility already strained by the

need to facilitate an appropriate closure process. Yet action on behalf of staff is necessary.

Closing Facility Interventions for Staff

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

Interventions to address this stress include the following:

- Allow the staff to verbalize their initial reactions.
- Assist staff in understanding the normalcy of the emotions they are experiencing.
- Let them know the facility will not be closing immediately. It will be open until the last resident is relocated.
- If at all possible, offer a financial package to help staff in determining if they will stay and assist in the relocation of the residents.
- Consider facilitating the staff to meet as a group to share their feelings on the closure and what it means to them.
- Let staff know the facility will be supportive as they seek future employment.
- Provide direction to available job services.
- Let other providers know the facility is closing and staff will be seeking new employment.
- Reassure staff by initiating action to provide job references.
- Assist with resume writing. It may be helpful to provide a class on the writing of resumes.

- Facilitate information sharing that is helpful in the job search. An area dedicated to resources for new employment opportunities should be developed.
- Keep 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.
- Assure staff that they will be given notice as soon as it is evident that their personal employment will be ending on a certain date. Procedures for noticing staff on potential lay offs need to be discussed openly and before the lay offs actually begin.

Staff In-service

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

Staff Role in Resident Relocation

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

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 knows the resident’s individual preferences. They can assist the new facility/service provider in learning this critical information.

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

Summary

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

Experienced staff needs 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 relocation stress syndrome 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

Technical Assistance Document: Minimizing Emotional Stress During a Downsize or Closure for Persons with Developmental Disabilities/Intellectual Disabilities/Brain Injury

On being informed that an Intermediate Care Facility for Persons with Intellectual Disabilities (ICF-ID) or a community based residential facility (CBRF) is closing or downsizing, a Resident with developmental disabilities (DD) or intellectual disabilities (ID) or brain injury (BI) or his/her Guardian may experience emotional stress due to significant changes in their environment.

Some of the Residents may have resided in their current homes for 30 years or more. The staff functions as their support and friends. The same function may be said of their peers.

The Goal of Resident Relocation

The objective is for the Resident/Consumer to become more fully integrated into their community. This is to be accomplished by meeting their identified Personal Outcomes and individualized needs as defined in their Member Centered Plan or their Individual Support Plan (ISP) and his/her resident relocation/transition/discharge plan.

One less time consuming but very important piece of the relocation is the transfer of the Resident information that will constitute his/her safe and appropriate records, the orientation of the new care providers by the care givers in the closing or downsizing facility, and the realization that communication of the factors that make the resident a unique person are critical to the well being of the resident and his/her successful relocation.

The Foundation/Elements for Best Practice in Relocation and Transitions for the DD/ID/BI Population

Getting to know the Resident is accomplished in a variety of ways including but not limited to:

- Interacting with the Resident.
- Having conversations with the Guardian.
- Having conversations with the current and future staff.

- Taking the Resident on a community outing with current staff.
- Identifying what the Resident likes, does not like, sleep habits, grooming habits etc.
- Learning how the Resident, both positively and negatively, reacts to stress.

Providing Choice to the Resident/Consumer and Guardian

The Aging and Disability Resource Center (ADRC), Independent Consultant from IRIS (Include, Respect, I Self Direct) Program, Managed Care Organization (MCO) or county staff from Waiver Programs will get to know what the Resident/Consumer and Guardian preferences are by the following methods:

- Having conversation with the Consumer and Guardian regarding what type of residential setting she/he prefers.
- Talking to the Consumer and Guardian about work preferences and options.
- Discussing if the Consumer and Guardian would like to live with certain friends.
- Discussing with the Consumer and Guardian if there are people to avoid living with.
- Showing the Consumer and Guardian a variety of residential and work type settings in order to make an informed choice.

Best Practice to Minimize Potential Emotional Stress

The MCO, Waiver County Agency or Independent Consultant (IRIS) will work with current staff to learn about and problem solves any behaviors that the Resident normally does not display to discern if the Resident is experiencing emotional stress. Some of the following behaviors could be associated with emotional stress:

- Feeling of loneliness.
- Intrusive behaviors.
- Exhibiting isolating behaviors.
- Loss of appetite.
- Appearing sad.

- Refusing to do activities of daily living (ADL) such as bathing, exercising, exhibiting poor hygiene all of which are out of character for the Resident

In an attempt to communicate the internal stress that a Resident may be experiencing, she/he may engage in a variety of behaviors that could be negative in appearance. Some of these behaviors may include:

- Destruction of property.
- Agitation.
- Elopement.
- Aggression to staff and/or peers.
- Unwillingness to participate in community activities, work, and social outings that they typically enjoy.

Guardian and Staff Fears

Best practice includes many conversations with the Resident and Guardian. Guardians and current staff may have fears regarding the upcoming transition due to facility downsizing or closure. Questions should be openly discussed and options should be given to the Resident and Guardian. *See the section above regarding choice.

Many of the fears and apprehension of the Resident and Guardian stem from the “Unknown”:

- Who will advocate for the Resident?
- What will happen to the Resident when she/he moves out?
- Who will protect the Resident from being victimized in the community?
- Who will the staff be?
- Where will she/he live?
- Where will she/he work?
- How will she/he stay connected to family, friends and other important people in their life?

Interventions to Mitigate Stress

The closing facility staff should invite the staff from potential new settings to come to meet the resident. The new staff should be invited to participate in discharge planning meetings. They may need to attend more than one meeting and observe and interact with the resident on several occasions.

The Resident should visit potential new alternate settings. It may be important that she/he visit more than once.

Once the Resident has chosen a new living setting, she/he may benefit from seeing pictures of it to remind him/her that this is where he/she will be moving. It may be beneficial to have him/her spend some time at the new facility including over night.

When the Consumer actually moves, staff from the closing facility should accompany and assist him/her in settling into the new environment. During the actual relocation the accompanying staff should have discussions with the Consumer and the new staff to ensure that staff has all of their questions answered; that the Consumer is feeling comfortable and he/she is a welcomed addition to the new setting.

The former facility staff needs to maintain availability to staff in the new alternate setting to answer questions and help them in looking at needed interventions and adjustments to the Consumer's Member Centered Plan or ISP.

Follow Up

Managed Care Organization

The Member Care Quality Specialist (MCQS) from the Office of Family Care Expansion and the MCO will follow up with the Member after the relocation to the community on an individualized and as needed basis.

Waiver County Agency

The Area Quality Specialist (AQS) formerly know as a Community Integration Specialist, (CIS) will follow up with the Consumer at the 30 day, 90-120 day intervals and annually for three years while he/she is enrolled in

the Community Integration Program (CIP) Waiver. Additional targeted reviews can occur at any time and more frequently as needed. CIP reviews can also include file reviews, random reviews and targeted reviews.

The purpose of the MCQS and AQS follow up is to assure health, safety and compliance with the Waiver System that is funding the Member Centered Plan or ISP once the Consumer moves out of the institutions.

Residents with Mental Illness Diagnoses Relocation Stress Syndrome

On being informed a nursing home/community based residential facility is closing, the resident with a diagnosis of mental illness will experience the same emotions as residents without mental illness who suddenly hear they are going to be forced to relocate from their home. Based on the extent of suddenness of the closure announcement, the resident will probably experience shock, sadness, confusion, and frightened feelings. The resident will also experience grief over their perceived losses.

For residents who have already experienced facility closure and relocation, this relocation may represent another loss of trust and a sense of betrayal when they are faced with the loss of what they viewed as a permanent home.

The resident with mental illness experiences the same emotions of any resident with an unexpected loss of familiar environment and friends.

Factors Impacting Resident Reaction

- Lack of prior knowledge of possible closure.
- Other emotional stressors occurring at the same time as the closure announcement.
- Low social support from family and friends.
- Finality of the decision to close the facility.
- Ability to engage any coping mechanisms.
- Age of the Resident.

Resident Losses/Stressors

- Loss of familiar physical environment.
- Loss of friends – other resident relationships.

- Loss of familiar staff – support system.
- Potential loss of care manager depending on the area of relocation.
- Potential change of entire service system staff.
- Uncertainty about what options are available to them.

Interventions to Mitigate Stress

Reinforce the fact that resident verbalizations and behaviors are probably normal and proportionate to the closure news they have just received. The resident reaction is, more than likely, not a direct manifestation of their mental illness. Their reaction is based on the news of facility closure and fear of the unknown. The resident is experiencing Relocation Stress Syndrome.

Interventions to mitigate relocation stress syndrome include:

- Having supportive service providers present at the time of the announcement to reassure the resident.
- Having family/representatives and/or friends present to support the resident
- Reviewing how the resident usually handles stress.
- Planning interventions based on how the resident usually handles stress and subsequent successful interventions.
- Seeking assistance and direction for addressing new resident needs and behaviors that are not already care planned.
- Letting the resident verbalize their feelings/reactions to the news of closure and need for relocation.
- Listening to the resident when they are asking questions and discussing their feelings regarding having to relocate.

- Allowing the resident to be involved in planning their relocation.
- Reassuring the resident that they will have assistance and a choice in locating a new living environment.
- Considering the resident may desire to be relocated with other residents and may want to have another resident as a roommate.
- Working collaboratively with the resident and their case manager and or their representative in developing their discharge plan and implementing the relocation effort.
- Allowing the resident to be involved in planning their relocation.
- As indicated, accompanying the resident on tours of potential new living environments.
- Reassuring the resident that they will not be forced to leave immediately: they will not leave until an appropriate setting is found and the resident chooses the setting as their home.
- Recognizing the resident's pronounced vulnerability that exists on a psychological and physical basis. The vast majority of residents, with mental illness and who are forced to relocate, are unable to secure a new living environment without extensive assistance.
- Recognizing the resident's vulnerability to depression. The potential for the onset of depression or escalation of already existing depression underscores the need to early on involve the resident's psychiatrist in the relocation process.
- Informing the psychiatrist that the resident is undergoing an additional major stressor in the form of resident relocation stress: the psychiatrist needs to be asked for input into the care planning for RSS specifically and into the relocation process generally.
- Securing the psychiatrist's input for review by both the interdisciplinary team and if indicated, the state relocation team.

- Recognizing that depression may lead to related illnesses. Monitor the resident's physical and mental condition for changes including in habits such as the activities of daily living, appetite, food and fluid intake, activity level, and any isolating behaviors.

Relocation to a More Independent Setting

Prior to the announcement of facility closure, some of the residents may have had relocations to a more independent setting already planned. These prior planned relocations will be less stressful for the affected residents.

Some of the longer term residents may find themselves being relocated to a more independent setting. They may find themselves in a supervised apartment setting, an independent apartment with services, or transitional housing. This will represent a tremendous change from a very sheltered living environment to dramatically more independence.

For some residents, their main or only support system may be the closing facility direct care staff. The other residents may be their only friends and confidants. These residents are particularly emotionally vulnerable during this time of pronounced change.

It is important that the resident be assessed for their level of independent functioning and any identified deficits be addressed to allow for a successful relocation to the more independent setting.

References

Farhall J., Trauer T., Newton R., and Cheung P., Minimizing Adverse Effects on Patients of Involuntary Relocation from Long-Stay Wards to Community Residences. *Psychiatric Services* 54:1022-1027, July 2003

Resident/Client Relocation Stress Syndrome Care Managers/Community Service Providers

Chapter 50: governs the closure of nursing home and community based residential facilities with the primary focus being on the resident who is being relocated from their home to an appropriate placement/setting.

50.03(14) states “the department may provide, direct or arrange for relocation planning, placement and implementation services in order to minimize the trauma associated with the relocation of residents and to ensure the orderly relocation of residents.”

The terms Relocation Stress Syndrome (RSS) and Transfer Trauma (TT) are used interchangeably when discussing the emotions and psychological impact experienced by a resident who is forced to relocate due to closure of the facility where they reside.

There is a need to address RSS with residents relocating to the Community. The increasing numbers of residents relocating to community settings from nursing homes has brought forward the need to better address the relocation stress the individual may be enduring after their relocation to a more independent setting. Based on resident follow up by relocation team members, there is evidence some clients may initially become withdrawn and isolating when relocated to community settings. The individuals do experience real fear of the “unknown” and exhibit characteristics of RSS.

Significance of RSS due to Nursing Home/CBRF Closure

When the announcement is made that a nursing home/CBRF (community based residential facility) is closing, the resident has no other alternative to the realization that they will be moving relatively soon from the facility they may have considered their home. This is the facility where they may have felt relatively safe and secure. The resident, depending on offered programs, may have a short term goal of returning to the community. However most of the residents may not be contemplating movement to a more independent setting.

Some of the residents may welcome the closure announcement, as the need to relocate may facilitate a relocation they desired but was not imminent if

planned for at all. Most of the residents will not welcome the closure announcement.

Based on resident follow up visits by members of the relocation team, information gained from resident and representative feedback indicates the major portion of residents initially view the relocation as a shocking and frightening development. For a number of residents, this relocation may not be the first time they have been forced to move from a closing facility. They have lost trust that an appropriate and lasting placement will be found. All residents have a sense of loss of control and predictability in their lives. This is at least an initial response and for some residents it is a persistent response.

Residing in a licensed facility means the resident will be adapted to a certain life style. There will always be a person on duty to respond to their needs. All meals will be provided for them. There are very limited personal housekeeping responsibilities if any at all. They are not planning their finances to address household expenses and paying bills. If they need medical intervention it is most often sought for them. The facility itself presents an environment conducive to physical safety. It is more than likely accessible in all aspects including the bathroom and entrances and exits. Visitor traffic in and out of the facility is controlled.

While the resident in a nursing home/CBRF is living in a more restrictive environment, they are also having their needs addressed in a care/service plan. The facility may represent a safe and comfortable environment and atmosphere. The certainty of leaving the known environment and relocating to a more independent environment will potentially present a challenge for a potentially vulnerable resident. The resident will experience relocation stress syndrome before their move.

State Relocation Team

The State Relocation Team consists of the facility, the Aging and Disability Resource Center and or the county long term support staff, the advocacy agencies (the ombudsman from the Board on Aging and Long Term Care and staff from Disability Rights Wisconsin), and the Department of Health Services, Division of Long Term Support.

Relocation Stress Syndrome - Definition

Relocation Stress Syndrome was adopted as an official nursing diagnosis in the early 1990s. It is defined as “Physiologic and/or psychosocial disturbances as a result of transfer from one environment to another.” (NANDA International formerly North American Nursing Diagnostic Association, 1992)

Five resident/patient characteristics that may occur with RSS/TT are:

- Dependency
- Confusion
- Anxiety
- Depression
- Withdrawal

Prior Relocations

The staff of community agencies may already have extensive experience dealing with persons experiencing relocation stress syndrome. The client may have experienced multiple episodes of unanticipated relocations. They most likely have also experienced multiple episodes of RSS.

Interventions to Minimize Relocation Stress Syndrome

What actions may be taken to assist the resident in coming to acceptance of the fact that the facility is closing and that they will be assisted to have a successful relocation to a more independent setting in the community?

When the closure announcement is made to residents, the Chapter 50 relocation team is often present to inform the residents and families, and or other representatives of the closure process, including the amount of time that might elapse before a facility may close and of available options and supports. It is important that residents are reassured that they will not be moved until they have a choice regarding where they will be relocated. A calming atmosphere is important. Still, emotions described by residents who have had relocation team follow up visits include the following.

“Shock, I cried, would any body want me, where would I go and would my visitors still be able to visit me.” Residents also verbalized not wanting the

facility to close. A resident at another facility questioned the need to move saying this is the “Best place I ever lived!”

It is important that care managers collaborate with facility staff to address interventions to assist the resident cope with their relocation. This needs to occur at the time of the closure announcement. The staff needs to recognize signs and symptoms of resident RSS and appropriate interventions for the individual residents.

When indicated, care managers, in collaboration with the facility, may be the appropriate persons to seek the assistance and advice of the residents’ psychiatrist, attending physician, and/or other appropriate health professionals.

Anticipated Responses

What are some of the changes in resident behavior that may be anticipated both after the facility closure/resident relocation announcement and then after the resident’s relocation?

Resident behavior characteristics that appear to be either new or changed may include the following:

- Expressions of depression/sadness.
- Expressions of anxiety/apprehension.
- Expressions of anger, irritability.
- Withdrawal, social isolation.
- Verbalization of insecurity, dependency, increased need for reassurance.
- Verbalization of a lack of trust.
- Wandering, sun downing.

- Exhibiting increases in negative behaviors, hostility, belligerence, intrusiveness toward others.

*Always physical changes must be considered when evaluating behavior changes. Among changes in health status that the resident may be experiencing are weight loss, urinary tract infections or cardio vascular changes including transient ischemic attacks.

Changes Impacting Resident RSS

Almost all residents will realize that their life is changing as appropriate placements are sought:

- Their known environment starts to change. Familiar residents will begin to be relocated from the facility and may include the residents' roommates and friends.
- Staff attrition may result in unfamiliar caregivers and the potential for new and unfamiliar routines for care.
- The resident's actual room location may change as a facility reduces staff levels and the utilization of space.
- The resident may begin touring potential new settings emphasizing the reality of the impending closure.

Minimizing/Mitigating Resident Relocation Stress Syndrome

Recognize that the resident, will to varying degrees, experience relocation stress syndrome. The resident is relocating because they are being discharged on an involuntary basis. Again, the relocation may be in the same city or town or 50 plus miles away. No matter how far it is geographically, the relocation is a huge change for the resident to assimilate.

If the resident is to have a new case manager in the community, they need to meet them before relocation planning is complete. The new case manager needs to participate in the planning and execution of the resident's relocation.

The resident needs to choose their new living environment. They need to be active participants in planning and executing their relocation. Their new location needs to consider the feasibility of any visitors being able to get to the new location.

If necessary, transportation and medication management services need to be arranged along with other necessary services.

The resident needs to have the skills necessary to have a successful relocation to the community setting. If they do not have these skills there must be a workable plan for developing them. The resident must have confidence in their ability to succeed in the community and if necessary given the tools for achieving success.

If behavioral changes occur at the closing facility they need to be documented and care planned for. It is important that future service providers be aware of what normal behavior is and what behaviors represent a change.

The resident should have the process for relocation explained to them. The explanation and reassurance may need to be repeated several times. They are under stress and may not readily comprehend what is being said.

The resident needs to tour the potential relocation facility/settings and see where they may be relocated. Meeting new staff may help with their anxiety. The tours should be conducted if at all feasible. A resident may resist touring new settings. The offer to tour should be repeated at intervals as the resident may increase acceptance to the reality of the need for relocation.

Leaving a licensed facility to live in a community setting is a drastic change. It is helpful for the client to tour the setting so upon arrival the residents are not shocked at differences in the environment. Also a tour will help them decide what possessions to take and what other furnishings they may need. If they are not able to tour, pictures may help them prepare for the physical change in their environment.

If possible, the client meeting any staff from their new setting before the relocation and being made to feel welcome will decrease some of the stress over the relocation.

The new setting, if it employs staff, should conduct staff in service on RSS and strategies to mitigate the relocation stress the relocating client may be experiencing. The case manager can discuss content and resources for an in-service. It is suggested that this document be shared with service providers.

The service providers, receiving client authorized information, need to review all the transfer information that accompanies the client. They need to know the client, to the extent possible, in order to plan quality/adequate care and services for the resident.

The involved service providers need to know the identity of the client's physician(s), who to contact in an emergency and where the client goes to seek emergency care. The stress of the actual relocation may precipitate a rapid change in the client's health status.

Pay special attention to safety related issues. The new environment is strange and it may take time for the client to adapt.

If appropriate, provide the resident with at least parts of a routine as similar as possible to the previous experiences.

Service providers should have the closing facility telephone number and person to contact to expedite the communication for questions and issues that may arise after relocation.

Resident Transition on the Day of Relocation

It may be emotionally devastating for the client to physically leave the closing nursing home or CBRF to travel to a new place of residence.

If feasible and indicated, closing facility staff/case worker should accompany the resident when the actual relocation takes place. It is important that the resident's new physical environment be set up to reflect their preferences and how it may best function to serve their needs.

The client may arrive at their relocation setting feeling distraught and/or confused and afraid.

If possible, the client needs to be provided a sensitive and warm welcome.

If appropriate, closing facility staff should review resident needs and preferences with service providers. Many residents can't or won't express their preferences.

If present, encourage family and other resident representatives to stay while the client "settles in."

Have a plan and hopefully a specific person to support the resident on the first day of their relocation and thereafter as needed.

Identify the service providers the client and/or family or another provider is to contact with concerns. This identification coupled with a response will help solve problems before they occur. The family/representative is also stressed by the need to relocate the family member/resident. They are also unsure of their acceptance with new service providers. They may verbalize many concerns about the status of the client or they may be fearful of saying anything that could be construed as negative.

All appropriate records need to be transferred to authorized agencies and/or service providers to enhance the ability to determine if changes in behavior and physical condition are occurring. The ability to compare data for establishing any change in client health status is especially important for clients who have difficulty communicating any changes they may be experiencing.

Characteristics of Resident Relocation Stress Syndrome after Relocation

Upon relocation, the client may experience both physical and emotional changes. It is important, if appropriate and as stated above, that service providers have the information that allows them to assess these changes in status and to consider if the changes represent either a continuation or a new manifestation of RSS.

Some of the observed changes that may be the manifestation of the characteristics of RSS include the following items:

- Decrease in appetite or weight loss.
- Signs of dehydration.

- Decrease in ability to perform activities of daily living. (ADL)
 - Bathing
 - Dressing
 - Eating
 - Mobility
 - Toileting
 - Change in continence status
- Occurrence/increase in falls.
- Change in sleeping habits.
- Isolation from community activities.
- Making calls to the closing facility.
- Expressing concern over finances.
- Expressing concern over family and friends ability to visit.

Resident Follow Up

Relocation team members may do selected resident follow up after relocation to determine the effectiveness of the relocation process for residents.

The discharging facility may follow up on some residents during the relocation process. They should be available to serve as a resource for new caregivers and other service providers during the period of resident relocation and prior to facility closure.

The advocates, Ombudsman and Disability Rights Wisconsin, may follow up to ensure resident rights are being observed and to determine the appropriateness of the relocation and ways to improve the process.

The county waiver programs will have continued involvement with residents who choose to live in the community.

Residents who enroll in Managed Care Organizations will have care managers who follow residents in the community or in nursing homes when they are relocated there.

The Department of Health Services may do follow up with selected residents, families and other service providers.

The goal for all involved in the resident relocation process is to minimize/mitigate the effects of relocation stress syndrome on the residents.

References

“Relocation Best Practices for Discharging and Receiving Facilities” Resident Relocation Planning and Procedure Manual, Department of Health Services, July 2005

Mintz, T, Relocation Stress Syndrome in Older Adults, Social Work Today, Vol.5, No 6 P.38

Identification of Relocation Stress Syndrome/Transfer Trauma

Purpose: to ensure the rights of each resident observed during the Resident Relocation Process and to ensure each resident experiences a safe and appropriate relocation while minimizing relocation stress syndrome/transfer trauma (RSS/TT).

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

Symptoms: may include any of the following (1)

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

Strategies:

- Provide face-to-face meetings for resident and family/guardian to provide information and offer reassurances throughout process. Questions can then be addressed in a timely manner.
- Educate residents, families/guardians, and staff regarding relocation process so that all are aware of the process and who to contact with questions and concerns.
- Review Resident Rights and grievance procedures with residents and families/guardians.
- Remind all staff to seek assistance for residents and families/guardians when there are concerns.
- Closing facility to assess and implement temporary care plan to ensure process is resident focused and the resident needs are met throughout process.
- Closing facility to provide complete and appropriate information to receiving facility/setting/entity upon relocation.
- Receiving facility/setting/entity to create caring and welcoming environment for resident upon arrival.
- Receiving facility/setting/entity to assess and identify resident's risk for experiencing RSS/TT in their new home.
- Receiving facility/setting/entity to implement initial care plan to address resident's risk for relocation stress syndrome/transfer trauma.

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

Resident Relocation Stress Syndrome/Transfer Trauma Staff Education Draft

Note: The following content has been developed for staff education.

Goals of Training Program:

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

Resident Rights

- Right of privacy
- Right to make choices about health care
- Right to be free from abuse
- Freedom from interference, coercion 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 & Ombudsman Program)

Important Note

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

Strategies for Transferring Facility

- Assess resident and implement temporary care plan to ensure process is resident focused and resident needs are met.
- Assess resident preferences
- Fluid communication to all involved parties regarding discharge developments/referral outcomes
- Provide for the exchange of information between providers
- Face to face meetings with resident and family/guardian

- Encourage resident to be directly involved
- Encourage family/guardian to be involved
- Interdisciplinary team support
- Educate staff re: process and what to expect
- Provide opportunity and time for resident
- LISTEN to resident and family/guardian
- Maintain daily routines
- Be flexible as resident needs change
- Be aware that resident feels loss of control
- Frequent 1:1 visits with familiar staff
- Provide list of possible relocation sites
- Assist with scheduling visits to possible relocation sites
- Once relocation facility chosen, assist with transfer of information
- Upon acceptance at relocation facility, assist with paperwork transfer
- Dress in “finest”
- Allow time for resident to say farewell to staff and peers
- Allow “familiar face” to accompany

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
- Admission care plan to address risk for transfer trauma (falls, anxiety, weight loss...)
- Document resident's reaction and concerns on day of move
- Warm, friendly environment
- Unpack with resident
- Introduce to peers, volunteers and families
- Establish routine
- Assign consistent caregiver(s)

Assess for risk of Relocation Stress Syndrome/Transfer Trauma

- Assess for changes in 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/depression
- Use MDS tools/risk assessment tools

Care Plan Interventions

- Allow resident to verbalize
- Keep resident actively involved
- Monitor for change in behavior
- Monitor for change in abilities (ADL, mobility)
- Monitor for decline in cognitive status

- Monitor appetite and I&O
- Weekly weights looking for change
- Monitor for complaints of increased pain

Section VIII

Appendices

Appendix A
Sample
Resident Relocation Plan Review Checklist

Facility Name _____

Completed Date of Review _____

Check each item when approved as part of the facility relocation plan:

- ___ Reason for Closure
- ___ Proposed Date of Closure _____
- ___ Plan to involve county ADRC, Waiver Programs, APS
- ___ Plan to involve other counties with legal and or financial responsibility
- ___ Designation of the facility's Relocation Coordinator
- ___ Relocation Planning and Implementation Timetable
- ___ Notices: Including the Following
 - ___ Intent to Close
 - ___ Discharge Notice – 30 Day
 - ___ Discharge Planning Notice
- ___ Resources, policies and procedures for
 - ___ Mitigation of Transfer Trauma/Relocation Stress Syndrome
 - ___ Persons with a mental illness, with a physical disability, who are elderly
 - ___ Addressing resident preferences/choice
 - ___ Visits to potential and resident preferred living arrangements
 - ___ Transportation plan for visits
 - ___ Staff approaches identified/how staff will assist residents in their relocation
- ___ Full Completion of Resident Roster
- ___ Plan to involve the physician
- ___ Plan for resolution of complaints or concerns, reference HFS 94 Resident Rights
- ___ Relocation Planning Process/Securing an Appropriate Living Arrangement
 - How will resident be referred to the ADRC/County Waiver Programs
 - How will the facility interface with MCOs, IRIS, and County Waiver Programs in assisting the resident in the relocation planning/discharge process?
 - How will the facility facilitate the discharge planning conference?
 - How will the facility facilitate the actual relocation of the resident and their possessions?

Notes:

Appendix B Sample Resident Roster

This Split Roster is for Display Only. Submit as One Continuous Table.

RM#	Name	DOB	DOA Initial	DX	Special Needs	DD LOC	Name, Address, Telephone Number of Guardian, Activated Power of Attorney HC First Contact if Own Person	G (Guardian) A (ACTPOAHC) O.P. (Own Person) N (Needs GPP)	County & State of Appointment Guardian Protective Placement

VA (Voluntary)/ IC Involuntary PP (Protective Placement)	Payor Source PP (Priv. Pay) MC (Medicare) MA (Medicaid) FC (Family Care) MCO, Waiver Program	PASRR Screen I/II Active Treatment Status SNF Only	Case Manager/ Worker	County Assessment ADRC Options Counseling	County of Responsibility Legal Financial	Comments

Note: The Resident Roster needs to be on one continuous table. Do not separate into two parts.

Appendix C

Resident Roster

Instructions for Completion

1. Room Identifier: Current. Also if changed, the roster should be updated.
2. Name: Full legal name, do not use nick names. Sorted by last name.
3. Date of Birth: Use dd/mm/yyyy format.
4. Date of Admission: Use Initial Date, dd/mm/yyyy format.
5. Key or Primary Diagnoses:
 - Current Diagnoses for each resident.
 - Relevant Diagnostic History.
 - Mental Illness.
 - Developmental Disability.
6. Special needs: Those items, services equipment and/or care protocols, which the resident relocation team needs to be aware to plan discharge. Include smoking status, active treatment status, AODA treatment, English as a Second Language Status (ESL), current behaviors exhibited for which the facility has a care plan.
7. Name, Address, Current Phone Number of Guardian or Activated POAHC or if the resident is their own person, the resident's first contact person.
8. Guardian/Activated POAHC or Own Person: Designate current status by using G = Guardian, APOA = Activated POAHC, O.P. = Own Person, N = Needs GPP. This is the current status as confirmed by facility. As necessary, the facility needs to be able to produce documents proving the legal status at the first relocation team meeting. PP=Protective Placement
9. County & State of Appointment of Guardian/PP: Name of county and state if the state is other than Wisconsin.
10. VA (voluntary admission), IC (involuntary commitment), PP (protectively placed).
11. Payer Source: Designate back up payment source for those Medicare residents by using MC/alternate. If Medicaid is applied for but pending designate with *asterisk. Private pay includes SSI, SS, trusts, VA pensions etc. If community waiver programs are the payment source indicate COP, CIP, CRI, Diversion Note name of MCO making payment. The MCO acronym is acceptable. If payment is from the county, but from non waiver program sources, please indicate community aids (CA).

12. PASRR: (for SNFs only) Indicate PASRR I/II screen is done by placing I or II in this field.
This is only applicable to SNFs. Note if receiving Active Treatment (AT) at the facility.
13. Care Manager: If the resident has a current care manager assigned from the county, an MCO or another community service provider put their name, agency name and telephone number in this space.
14. ADRC/County Waiver Assessment: This space is for the date the ADRC or county waiver program options counseling is completed.
15. County of Responsibility: This is the county of legal and or financial responsibility. Place the name of the county where the guardianship/protective placement was made or the county where the care worker is located. A resident may be their own person; however their original county may still be the county of financial responsibility. In that case the resident would still be considered a resident of that county. Otherwise this is the county where the facility is located regardless of which county the resident resided in prior to admission.
16. Comments/Notes: This area maybe used for any pertinent information the facility and relocation team determines is needed by the plan reviewer, relocation team. i.e. Guardian still pending, last Watts review date, active family involvement, pre-existing discharge plan date, results of options counseling occurring prior to the closure announcement, change in condition, and change in financial status. Include the address and telephone number of the alternative placement. Also include the name of the contact person. Include the name of the entity if there is one.

The facility is responsible for updating all information on the data roster for the first relocation team meeting and on a weekly or biweekly basis.

Note: SNFs do not need to list LOC or RUGS/CMI.

Note: The Resident Roster in the sample is in 2 parts for ease of viewing. It must be submitted in one continuous table/page.

Appendix D
Sample
Resident/Guardian/Agent Resident Relocation Notification Letter

<<Name >>
<<Address>>
<<City>>, <<State>> <<Zip Code>>

Dear << Name >>:

Due to _____, _____ has decided to close
_____.

As required per state law, _____ has submitted a Resident Relocation Plan to the State of Wisconsin on _____. We anticipate that we can successfully relocate each individual within the statutory required time frame; even so, the facility will remain open until each resident is properly relocated. Please be assured that we will be working very closely with you throughout the planning of your move to a nursing home or alternate living arrangement. 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,
- A comprehensive assessment will be completed and will be monitored by the State Resident Relocation Team and will assist in your exercise of choice,
- 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,
- 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, and
- You will have the opportunity to visit proposed settings.

We have designated _____ to be the facility Relocation Coordinator for _____ . He/she will oversee the relocation process and be available to answer any questions that you might have. The phone number is:
_____.

If you do not understand your rights regarding discharge, please contact _____ to assist you. He/she will help you exercise those rights. Your Ombudsman, _____, has also received a copy of this letter and can also help you through this process. He/she is available to be present at your discharge planning conference, if you desire.

_____, Long Term Care Ombudsman
State Of Wisconsin
Board on Aging and Long Term Care
<<Address>>
Phone number:

In addition, you may contact the following advocacy agency, which may assist persons with mental illness, developmental disability or physical disabilities:

Disability Rights Wisconsin
<<local office>>
<<address>>
<<city>>, <<state>> <<zip>>

We want to assure you that we will work very closely with you to assure that your relocation goes as smoothly as possible and that your questions and concerns will be addressed.

Sincerely,

(_____), Administrator

Appendix E
Sample
NOTICE TO PHYSICIANS

<<Name>>
<<Address>>
<<City>>, <<State>> <<Zip>>

<<Date>>

Dear (Attending Physician):

We are writing to inform you that due to (_____), <<name of parent organization>> has decided to close <<Name of facility>>. <<Name of facility>> plans to close within the required (90 – 120) 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. We ask for your assistance to help assure each resident's continuity of care.

(List Names Here)

During the next few weeks, we will be consulting with you regarding each of your patients at <<name of facility>> and the effects of the proposed relocation on his or her health. In the meantime, if you have any concerns or questions about our relocation plan, please contact me at (_____).

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,

(_____)
Administrator

Appendix F
Sample
Notice to (_____) County

<<Name >>
<<Address>>
<<City>>, <<State>> <<Zip Code>>

Dear << Name >>:

Due to (_____), <<Name of parent organization>> is formally notifying you in writing of our intent to close <<Name of facility>> within 120 days of the date of approval of the relocation plan. We have submitted/will submit a Ch. 50 Relocation Plan to the Department of Health Services, Division of Long Term Care for their review and approval. Once the Plan is approved, we will be working with representatives from your County and/or ADRC and other managed long term care entities to develop and implement individual relocation plans for our residents, as appropriate. County participation includes being a member of the relocation team, attending resident/family information sessions, coordinating referrals, screening, and attending routine scheduled relocation team meetings.

We have designated (_____) as the Relocation Coordinator for the facility. She will serve as your central point of contact and can be reached at (_____).

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,

(_____),
Administrator

Appendix G
Sample
INITIAL RELOCATION PLANNING CONFERENCE NOTICE

Date:

RESIDENT/DECISION-MAKER'S NAMES
ADDRESSES
CITY, STATE, ZIP

Dear M (_____):

This letter serves as a notice of your relocation planning conference at (FACILITY NAME/LOCATION).

The purpose of this meeting is to review the need for your relocation from (DISCHARGING FACILITY) and to discuss available options for alternate living arrangements. At this meeting, the effect of this relocation on you will be assessed and any changes in your plan of care to mitigate any stress from the move will be developed with your participation. This meeting should result in the development of a relocation plan that will address activities meant to assist you in planning your transfer from this facility. These activities could include options counseling, making arrangements for visiting potential alternate living arrangements, meeting with staff in that setting and developing a strategy for following up on results of your visit.

The meeting is scheduled for (DATE) at (TIME.)

You may invite, or decline to have present, any person of your choosing at this meeting. I recommend involving your friends/family members, your managed care organization case worker, your county care/case-manager, and as appropriate, your physician and an Ombudsman.

You may file a complaint about this discharge or discharge process by contacting the regional office of the Department of Health Services-Division of Quality Assurance by contacting:

NAME of RFOD
ADDRESS of REGIONAL OFFICE of the DQA
CITY, STATE, ZIP CODE
PHONE NUMBER

Please feel free to contact me to answer any questions about this notice or your impending discharge from this facility.

Thank you.

SIGNATURE
ADDRESS
CITY, STATE
ZIP
PHONE

Appendix H
Sample Care Plan –Relocation Stress Syndrome (RSS)

Problem	Goal	Interventions
<p>Resident at risk for signs /symptoms of Resident Relocation Stress Syndrome as evidenced by:</p> <p>Dependency Confusion Anger Depression Withdrawal Behavioral Changes</p>	<p>Resident will have any signs/symptoms of RSS prevented/mitigated.</p> <p>Resident will choose placement in an appropriate alternate setting.</p> <p>Resident will maintain current functional status.</p>	<ol style="list-style-type: none"> 1. Encourage presence of resident support persons when closure is announced, e.g. family, legal representative, case worker. 2. Identify for the resident and representatives who the facility relocation coordinator will be for the relocation process. 3. As indicated, provide a list of potential contacts such as advocates, county staff, ADRC, 4. Provide the opportunity for residents/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 primary staff person for the resident to relate to during the relocation process. Provide for continuity of direct care givers. 8. Update the interdisciplinary assessment/individual service plan to reflect resident’s desires/needs for

		<p>consideration in seeking an alternate living setting.</p> <p>9. Coordinate the resident planning conference to identify potential relocation settings.</p> <p>10. Coordinate visits and tours of potential facilities for relocation. Encourage resident and family / guardian to tour.</p> <p>11. Monitor resident for any changes in behavior related to the relocation process.</p> <p>12. Identify the resident's past coping techniques and if indicated, determine plan for using those in current relocation situation.</p> <p>13. Monitor the resident for any changes in physical status.</p> <p>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.</p>
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Appendix I

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 and any authorized decision-maker, to a known family member, legal counsel and the resident's physician (unless the resident requests that the family not be notified.) The notice must be made in writing and in a language and manner that's understood by the resident and others.

The written notice should be made at least thirty 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, or should immediate transfer be required by the resident's urgent medical need or should the resident's health improve sufficiently to allow a more immediate transfer. The resident may be discharged at his/her request or upon the informed consent of the resident's guardian. Should the resident elect to move sooner, or if he/she hasn't resided at the facility for thirty 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 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 closing facility may discharge the resident as the facility will cease to operate. The notice must explain the need for the relocation.

The written notice must state the location to which the resident is to be discharged/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 for and in advance of the discharge/relocation.

The written notice must state the effective date of the discharge/relocation. The resident may not be involuntarily discharged/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; the resident may appeal the discharge plan, they may not appeal the facility 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 Division of Quality Assurance 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 telephone number) for the nearest office of the Division of Quality Assurance 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.

Appendix J
Sample
THIRTY DAY DISCHARGE NOTICE – TEMPLATE

DATE:

RESIDENT/DECISION-MAKER'S NAMES
ADDRESSES
CITY, STATE, ZIP

Dear M_ (_____);

This letter serves as a notice of discharge from ___ (FACILITY NAME) ___.

The reason for your being discharged is the facility is closing.

The anticipated date of your discharge is ___ (DATE) ___.

The location to which you'll be moving is ___ (LOCATION) ___.

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 an Ombudsman (for persons over age 60) or a representative from Disability Rights Wisconsin (for persons under age 60.)

Board on Aging and Long Term Care
OMBUDSMAN'S NAME
ADDRESS
CITY, STATE, ZIP
PHONE
(800) 815-0015

Disability Rights Wisconsin
ADVOCATE'S NAME
ADDRESS
CITY, STATE, ZIP
PHONE

You may appeal your relocation or discharge plan by:

- 1) Writing a letter, within seven (7) days of having received this notice, to the regional office of the Wisconsin Department of Health Services – Division of Quality Assurance (DQA) asking for a review of the relocation plan and stating why this plan should not take place.
- 2) Sending a copy of the appeal letter to the administrator of this facility.
- 3) Within five (5) days of having received your written appeal, the facility must provide written justification for the discharge to the Wisconsin Department of Health Services –Division of Quality Assurance (DQA).
- 4) You may not be discharged, if you've filed a written appeal within seven (7) days of receiving this notice, until the Wisconsin Department of Health Services –Division of Quality Assurance (DQA) has completed its review and notified both you and the facility of its decision, within fourteen (14) days of having received written justification from the facility.
- 5) You may appeal the decision of the Wisconsin Department of Health Services – Division of Quality Assurance (DQA) in writing, to the Wisconsin Department of Administration, Division of Hearing and Appeals, General Government Unit within five (5) days after having received the decision by the Wisconsin Department of Health Services –Division of Quality Assurance.

The name/address/phone number for the regional office of the Wisconsin Department of Health Services – Division of Quality Assurance is:

DQA REGIONAL OFFICE
RFOD'S NAME
ADDRESS
CITY, STATE, ZIP
PHONE

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

FACILITY NAME
ADMINISTRATOR'S NAME
ADDRESS
CITY, STATE, ZIP
PHONE

The name/address/phone number of Wisconsin Department of Administration – Division of Hearing and Appeals is:

Division of Hearings and Appeals
5005 University Avenue Suite 201
Madison, WI 53705 – 5400
608 266 3865

Please feel free to contact me to answer any questions about this notice or your impending discharge from this facility.

Thank you.

(SIGNATURE)

PRINT NAME
ADDRESS
CITY, STATE, ZIP
PHONE

Appendix K

NOTICE BEFORE A DISCHARGE PLANNING CONFERENCE

Every resident has a right 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 and 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 relocation stress syndrome associated with the transfer.

The facility is expected to provide counseling regarding the impending transfer as well 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 his/her belongings and funds, and provisions for medications and treatments.

This planning conference must be held at least 14 days before the discharge is to occur and should include the resident, any authorized decision-maker for the resident, and any representative from an appropriate county agency, the resident's physician, and any other person designated by the resident.

Written notice of this planning session must be made at least 7 days before the planning conference. It must contain the date, time and place of the conference as well as a statement informing the resident that any persons of his/her choice may attend. It must include the procedure for submitting a complaint to the Department of Health Services.

A post discharge plan of care that identifies instructions for continued care and which assists the resident to adjust to his/her new living arrangement must be developed with the participation of the resident and his/her 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.

Appendix L
Sample
FORMAL DISCHARGE PLANNING CONFERENCE NOTICE
(Optional for CBRFs)

DATE:

RESIDENT/DECISION-MAKER'S NAMES
ADDRESSES
CITY, STATE, ZIP

Dear M (_____);

This letter serves as a notice of a formal discharge planning conference at (FACILITY NAME/LOCATION).

The purpose of this meeting is to finalize plans for your relocation to (ALTERNATE LIVING ARRANGEMENT) on (ANTICIPATED DISCHARGE DATE) At this meeting, the kinds of assistance to be provided to you in moving yourself, your belongings and funds will be discussed as well as making provisions for your continuing to receive medications and treatments. This meeting should result in the development of a post-discharge plan of care that includes instructions for your continued care in order to assist you in adjusting to a new living environment. At the time of your discharge and upon your consent, a summary of your status will be made available to authorized persons and agencies. A final statement of any funds or property that has been held by this facility for you will be prepared.

The meeting is scheduled for (DATE) at (TIME.)

You may invite, or decline to have present, any person of your choosing at this meeting. I recommend involving your friends/family members, your county care manager, as appropriate, your physician and an Ombudsman.

You may file a complaint about this discharge or discharge process by contacting the regional office of the Department of Health Services-Division of Quality Assurance by contacting:

NAME of RFOD
ADDRESS of REGIONAL OFFICE of the DQA
CITY, STATE, ZIP CODE
PHONE NUMBER

Please feel free to contact me to answer any questions about this notice or your impending discharge from this facility.

Thank you.

SIGNATURE
ADDRESS/CITY
STATE, ZIP
PHONE

Appendix M Sample

NOTICE OF WAIVER OF THE 30 DAY TIME PERIOD FOR A DISCHARGE

_____ I, (RESIDENT'S NAME/DECISION-MAKER) , have been informed of my right to receive a written notice of discharge at least 30 days before the anticipated date of that discharge. I choose to/circumstances dictate that I leave the facility before the 30 day period has lapsed and I waive my right to receive notice within that time frame.

_____ I have received a written notice of discharge on (DATE) . This notice states the reason for my being discharged, and the location to and date upon which I am to relocate. This notice informs me of and instructs me in how to file an appeal of this discharge/relocation decision. This notice provides me with contact information for the regulatory agency with which I can file an appeal and for advocacy organizations that can assist me in an appeal.

_____ I have been informed of my right to receive discharge planning and to have a discharge planning conference scheduled at least 14 days before the anticipated date of discharge. I choose to leave the facility before the 14 day period has lapsed and I waive my right to the formal discharge planning conference that adheres to these timelines. I understand I will receive discharge and relocation assistance as mandated in state and federal regulations. (For nursing homes and ICF-ID)

_____ I have been informed of my right to receive a written notice of this discharge planning conference within 7 days before that conference. I choose to leave the facility before the 14 day period has lapsed and waive my right to receive written notice of this formal discharge planning conference. (For nursing homes and ICF-ID)

(_____)
Signature – Resident or Agent

(_____)
Date

(_____)
Signature – Facility Representative

(_____)
Date

Appendix N Necessary Meetings

Initial Department/Facility Meeting – Initial meeting and consultation between the Department Relocation Coordinator and the involved facility representatives. The major area of discussion is the relocation plan. The discussion includes the facility operational status including resources available to aid the resident relocation process.

Announcement of Closure to Staff – Initial announcement to facility staff of the facility plan for closure/downsizing and relocation of residents. The announcement and subsequent discussion includes elements of the facility plan to address staff stress due to job implications.

Announcement of Closure to Residents/Family/Legal Representatives – Initial announcement of the facility intent to close and the relocation of residents. Members of the core resident relocation team are meeting participants and briefly present information on the process to attendees.

Informational Meeting for Residents/Family/Legal Representatives – The facts of the resident relocation process are presented to the residents and their representatives by the core relocation team and other involved stakeholders. Presenters include the State Relocation Team lead and the Member Care Quality Specialist, the facility, the county waiver programs and/or the Aging and Disability Resource Center, and representatives from the Board on Aging and Long Term Care, namely the relocation and/or regional ombudsman, and/or staff from Disability Rights Wisconsin. Other stakeholders presenting may include staff from managed care organizations and insurance plans.

State Relocation Team Orientation Meeting – This is the initial meeting of the core relocation team members which includes the facility. This meeting presents the opportunity for the discussion of team roles and the basic goals of the relocation team. This meeting is often held on the day of the announcement or informational meeting.

Staff Resident Relocation Stress Syndrome In Service – This in service is presented to assist staff in the mitigation of the relocation stress all residents will experience due to their need for an alternate placement. This in service is under facility auspices and may include presenters from the state relocation team.

Initial Relocation Team Meeting – This is the first, formal meeting of the state relocation team. At this meeting each resident has an in depth review, format expectations are set, and any concerns are discussed. All relocation team meetings are conducted by the state relocation team lead.

Regular Relocation Team Meetings – The relocation team meetings are conducted on a regular basis at the facility. Each resident relocation status is addressed at the meetings. Issues and concerns are addressed by team members. Facility operating status is reviewed with any concerns being addressed.

Lessons Learned – This meeting is convened by the relocation team lead after the last resident has been relocated and the facility has closed. The core members of the relocation team are present along with invited interested parties and other stakeholders. The purpose of the meeting is the evaluation of the resident relocation process and an update on the status of relocated residents. Results of state relocation team visits to relocated residents are discussed.

Appendix O Necessary Notices

Notice to the Department of Closure or Downsizing – The facility notifies the Department of Health Services, Division of Long Term Care, Resident Relocation Coordinator, that it is closing or downsizing. The notice to the Department needs to occur before any announcement of closure or downsizing to other stakeholders such as residents, staff, and the community.

Notice of Closure or Downsizing to Residents/Families/Legal Representatives – The facility notifies the residents and their representatives of the plan to close and to relocate residents to an alternate placement. This announcement may take the form of a verbal announcement followed by a written notification. This announcement should occur after the relocation plan has been approved and in conjunction with the state relocation team.

Notice of Closure Addressed To Attending Physicians – The facility notifies attending physicians of their intent to close and relocate their residents to an alternate placement. The letter describes the role of the physician in the relocation.

Notice of Closure Addressed to the County and or the Aging and Disability Resource Center – The facility notifies the involved county programs including the waiver programs and adult protective services and or the ADRC when present. Other counties, who have legal and or financial responsibility for one or more residents are also notified.

Notice of Resident/Family/Legal Representative of Informational Meeting – The facility notifies the resident and their representatives of the date and time of the informational meeting that will be conducted by the members of the state relocation team which includes the facility. This meeting usually closely follows the announcement of closure meeting.

Notice of Initial Relocation Planning Conference – The facility, in collaboration with the resident and their representatives, schedules an individual resident relocation planning conference. This is the initial resident planning conference to review options for determining an appropriate alternate placement and to determine the need for options counseling.

The facility notifies the resident and or their representatives to the time, place and goals of the conference. If the resident is a member of a managed care organization (MCO,) the MCO is also notified of the meeting and invited to attend. If the resident is not a member of a MCO the appropriate county agency is also notified. When it is appropriate, Adult Protective Services (APS) is also notified.

Notice of Discharge/30 Day Discharge Notice – The facility provides a 30 day discharge to residents once the resident has chosen an alternate living placement. The notice informs the resident of their right to appeal their discharge/individual relocation plan to the appropriate regional office of the Division of Quality Assurance. The facility also notifies the physician and the MCO if the resident is a member. If indicated the facility also notifies the appropriate county agencies which may include Adult Protective Services (APS).

Notice of Discharge Planning Conference – The facility provides notice of the discharge planning conference schedule for the resident who has chosen and alternate living placement. The purpose of the discharge planning conference is to affirm plans for meeting the goals of the resident relocation. The facility notifies the resident, their representatives, the physician, the MCO if the resident is a member or will be upon discharge or the appropriate county agency.

Notice of the Right To Waive the 30 Day Discharge Notice Requirement and the Right to Waive the Discharge Planning Conference – The resident or their representative has the right to waive the 30 day notice of discharge and move sooner. The facility notifies them of this right and affords them a waiver form to sign. They may also waive their right to the formal discharge planning conference referenced with the 30 day notice. They retain their right to appropriate discharge planning as mandated in state and federal regulations.

Section IX

Optional Sample Forms

Transferring Facility Checklist Sample

TASKS	DATE / INITIALS
Resident and family /guardian informed	
1:1 meeting with resident / family / guardian	
Interdisciplinary team meeting to identify resident needs/resident desires	
Identify possible relocation options	
Coordinate tours of possible relocation facilities with resident / family / guardian	
Provide resident / family / guardian with tool for comparison	
Meet with resident/ family / guardian re: choice (obtain consent to share info)	
FAX resident information to possible receiving facility of choice for consideration	
Meet with resident / family/ guardian once accepted at new facility and begin planning for move and schedule transfer	
Prepare transfer paperwork (including medical record)	
Assist resident to inventory and pack belongings	
Confirm resident finances and disburse refunds to resident / family / guardian	
Prep resident day of transfer (shower, clean clothing)	
Afford resident / family / guardian opportunity to say good-bye to peers and staff	
Assign and send familiar staff person to escort resident to new facility	
Address resident's grievances throughout process	

DISCHARGE PROCESS
DISCHARGE INFORMATION PACKET CHECKLIST
Sample

RESIDENT: _____ DISCHARGE DATE: _____

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

Date	Initial	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 / POA/ 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 Last 4 weeks (_____ to _____)
_____	_____	Most Current Physician Orders
_____	_____	This month's Med Sheets
_____	_____	This month's Treatment Sheets
_____	_____	Copies of lab and diagnostic tests last 3 months
_____	_____	Most Recent MDS (Date : _____)
_____	_____	Identification Cards
_____	_____	Financial Reconciliation
_____	_____	Possession Inventory

Discharge Planning Check List - Sample

Resident:

Completed	Date Completed	Discharge Planning Process	Follow Up Needed/Comments
		Facility Closure Notice Given	Letters sent to resident and Responsible party
		1:1 Discharge meeting	
		Schedule Meeting – Date: _____	
		Letter Sent – Confirmation of Meeting	
		Waived meeting – return letter	
		Meeting Held: ___ In person ___ Other	
		Resident Present	
		Responsible Party Present	
		Education Needs Addressed	
		Review of Relocation Process Completed	
		Review of Discharge Options Completed	
		Review of Rights/Appeal Rights	
		Review of goals	
		Review of D/C goals	
		Support needs reviewed	
		Assessment process reviewed	
		Release of Information process reviewed	
		Onsite Visit Scheduled – potential location	
		Onsite Visit Completed-potential location	
		30 Day Notice Given – specific location	
		POA/Guardian in place	
		PASAAR Completed and Up to Date	

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Discharge Planning Check List - Sample

Resident:

Completed	Date Completed	Discharge Planning Process	Follow Up Needed/Comments
		Determine Support Needs	
		Equipment Needs	
		Adaptive Equipment	
		Wheel Chair	
		Other DME	
		Community Placement Needs Home Health Therapy Meals Other	
		Education Completed Medication Administration Treatments Diagnosis Nutrition Leisure Other	
		Assessments Completed – Final Nursing Social Services Nutrition Other	
		Discharge Transportation Set	
		Follow Up Clinical Appointments	
		Documentation Sent with Resident For D/C Physicians Orders Rx if Needed Medications sent Nursing Assessment D/C Summary History and Physical CXR Communicable Disease Statement Immunization Records MDS – recent Care Plan Social Service Documentation Other:	
		Personal Belongings Inventory Sent	
		Transfer Trauma information Sent to facility	

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**Sample
Discharge Plan Summary**

Resident :(_____)

MR# if applicable _____

Discharged to: (Name & Address)

Discharged with Whom/Relationship:

Discharge Date: _____ Time: _____ Transportation: Family Friend Medical Van
 Other

Home Health Agency: _____ Agency Contact Person:

Phone: _____ Fax: _____

Nursing Skilled Services recommended :(check all that apply): Hospice Wound Care Pain
Management

Med Set Up IV/Tube Feeding Oxygen / Teaching and training Diabetic teaching and training
Other

Rehab Therapies: PT OT SPEECH

Home Safety Eval Home Health Aides (Bath assist) Social Worker Other

No Skilled Services Indicated /Requested: _____

Date discharge order received: _____ **Equipment Recommended**

Primary Care Management Agency: _____ **Phone #** _____ **Start
Date:** _____

Community Resources / Additional Information :

Family Contact: _____ **Phone #**

Participation:

Social Worker: _____ **Date:**

AFTER CARE INSTRUCTIONS

Admitting and Current Diagnoses: (Medically defined conditions);

Discharge Vital Signs: _____ Temperature _____ Pulse _____ Respirations _____
 _____ B/P

See Immunization Sheet _____

See Medication sheet _____ See Treatment sheet _____ See current Physician orders _____

Recapitulation of Functional Status – Nursing

Current Assessment Information	Summary of Resident Stay	Current Assessment Information	Summary of Resident Stay
Behavior ___ No Problem ___ Needs Redirection ___ Withdrawn ___ Agitated ___ Wanders ___ Combative/Abusive ___ Other _____	___ No change from admission Change _____ _____ _____ _____ _____	Orientation ___ Alert ___ Oriented to ___ self _____ time _____ place ___ Forgetful ___ Comatose	___ No change from admission Change _____ _____ _____ _____ _____
Safety ___ Frequent Falls ___ Side Rails ___ Restraints ___ Alarms ___ Explain Other: _____	___ No change from admission Change _____ _____ _____ _____	Infection Control ___ No Infection ___ Infection TYPE: _____ _____ _____	___ No change from admission Change _____ _____ _____ _____
Skin Condition ___ Intact ___ Pressure Sores ___ Wound/Ulcer ___ Skin Care ___ Surgical Incision ___ Rash ___ Specialty Bed ___ Other _____	___ No change from admission Change _____ _____ _____ _____ _____	Special treatments ___ None ___ Oxygen/ Liters ___ ___ Tracheotomy ___ Old ___ New ___ IV fluids ___ Type _____ ___ Site _____ ___ Hyper alimentation ___ Blood Transfusions ___ Drainage tubes ___ Blood Glucose	___ No change from admission Change _____ _____ _____ _____ _____

Oral / Dental <input type="checkbox"/> Own teeth <input type="checkbox"/> Dental caries <input type="checkbox"/> Partials <input type="checkbox"/> Dentures <input type="checkbox"/> Appliance	No change from admission Change <hr/> <hr/> <hr/> <hr/> <hr/>	Communication <input type="checkbox"/> Intact <input type="checkbox"/> Non-verbal <input type="checkbox"/> Makes needs/wants known <input type="checkbox"/> Expresses thoughts/ideas <input type="checkbox"/> Alternate Communication system <hr/> <input type="checkbox"/> Visually impaired <input type="checkbox"/> Hearing impaired <input type="checkbox"/> Primary language barrier <input type="checkbox"/> Yes <input type="checkbox"/> no Language	No change from admission Change <hr/> <hr/> <hr/> <hr/>
Dietary / Nutrition <input type="checkbox"/> Diet _____ <input type="checkbox"/> Texture _____ <input type="checkbox"/> Swallowing issues <input type="checkbox"/> Chewing issues <input type="checkbox"/> Intake _____ <input type="checkbox"/> Other <hr/> <input type="checkbox"/> Height _____ <input type="checkbox"/> Weight _____	No change from admission Change <hr/> <hr/> <hr/> <hr/>	Social Functioning <input type="checkbox"/> Independent activities <input type="checkbox"/> Group activities <input type="checkbox"/> 1:1 Activities <input type="checkbox"/> At ease interacting with others <input type="checkbox"/> At ease doing planned / structured activities Self initiated activities Establishes own goals	No change from admission Change <hr/> <hr/> <hr/> <hr/>
Dressing <input type="checkbox"/> Independent <input type="checkbox"/> Supervision <input type="checkbox"/> Limited Assistance <input type="checkbox"/> Extensive assistance <input type="checkbox"/> Total Care	No change from admission Change <hr/> <hr/> <hr/>	Grooming <input type="checkbox"/> Independent <input type="checkbox"/> Supervision <input type="checkbox"/> Limited Assistance <input type="checkbox"/> Extensive assistance <input type="checkbox"/> Total Care	No change from admission Change <hr/> <hr/> <hr/>
Bathing <input type="checkbox"/> Independent <input type="checkbox"/> Supervision <input type="checkbox"/> Limited Assistance <input type="checkbox"/> Extensive assistance <input type="checkbox"/> Total Care	No change from admission Change <hr/> <hr/> <hr/>	Toileting <input type="checkbox"/> Independent <input type="checkbox"/> Supervision <input type="checkbox"/> Limited Assistance <input type="checkbox"/> Extensive assistance <input type="checkbox"/> Total Care	No change from admission Change <hr/> <hr/> <hr/>

Eating <input type="checkbox"/> Independent <input type="checkbox"/> Supervision <input type="checkbox"/> Limited Assistance <input type="checkbox"/> Extensive assistance <input type="checkbox"/> Total Care	No change from admission Change _____ _____ _____	Bed Mobility <input type="checkbox"/> Independent <input type="checkbox"/> Supervision <input type="checkbox"/> Limited Assistance <input type="checkbox"/> Extensive assistance <input type="checkbox"/> Total Care	No change from admission Change _____ _____ _____
Transfers <input type="checkbox"/> Independent <input type="checkbox"/> Supervision <input type="checkbox"/> Limited Assistance <input type="checkbox"/> Extensive assistance <input type="checkbox"/> Total Care	No change from admission Change _____ _____ _____	Walking <input type="checkbox"/> Independent <input type="checkbox"/> Supervision <input type="checkbox"/> Limited Assistance <input type="checkbox"/> Extensive assistance <input type="checkbox"/> Total Care	No change from admission Change _____ _____ _____

Home Management: (Meal preparation, cleaning, finances, shopping etc.)

Independent
 Assist
 Unable

No change from admission
 Changes, Comment below

CONCLUSIONS AND SIGNATURES:

The discharge instructions and recommendations have been reviewed with me: ___yes ___no

I have received and been instructed on how to take medications listed on the discharge summary: ___yes ___no ___N/A

I have received my personal belongings including those from the safe and any money kept in the trust account: ___yes ___no

I understand the contents of the discharge summary and instructions: ___yes ___no ___N/A

(_____)
Resident

(_____)
Date

(_____)
Responsible party

(_____)
Date

(_____)
Discharge Staff

(_____)
Date