Long Term Care Facilities

(See also Voluntary Admission and Involuntary Examination)

Alternatives to the Baker Act

Q. I'm a Circuit Court Judge. What can we do to prevent the unnecessary transfer of frail elders from nursing homes to psychiatric facilities? These transfers can cause great harm to these individuals.

Regarding the discussion of harm to transfer of elders from long-term care facilities to Baker Act facilities, research shows a real danger from this practice. A journal article titled "A Brief Literature Review of the Effects of Relocation on the Elderly" September 23, 2002; has the following highlights:

- Relocation can have negative physical and psychological effects on patients in acute care and residents of long term care. These effects are more pronounced in elderly populations, particularly frail elderly patients and long term care residents.
- Acute care patients and long term care residents are at an elevated mortality risk when they are relocated. Studies examining the effect of transferring (relocating) different patients groups between institutions have found that transferred patients were at an elevated mortality risk between 1.99 and 3.76 times greater than those patients who were not transferred.
- Contradictory studies that have not found an increased mortality risk for transferred patients often have methodological problems. Some of the methodological concerns include small sample sizes, inadequate statistical power and a lack of control groups.
- Based on 40 years of documentation and observation, Relocation Stress Syndrome was recognized as an official Nursing diagnosis in 1992 and was defined as the physiologic and psychosocial disturbances that result from transfer from one environment to another.
- According to the U.S government's Administration on Aging, Transfer Trauma, as a result of sudden and unexpected relocation, is associated with depression, increased irritability, serious illness and elevated mortality risk for the frail elderly.

The Florida Health Care Association has developed a model policy and procedure titled "Behavior Management / Aggression Control / Baker Act Guidelines". This document has the basic standards that a good nursing home should be following before a voluntary or involuntary transfer under the Baker Act takes place. It might be the core of what could be promulgated by DOEA or AHCA to better protect our elders. It is included in the state's Baker Act Handbook in the chapter dealing with long-term care facilities.

Q. An ALF called our law enforcement agency about an elderly resident who refused her medications for a couple of days (diabetic and blood pressure) and became belligerent with staff and other residents. ALF staff contacted the resident's physician, who said he couldn't sign the BA-52 because he hadn't seen the person recently. The resident didn't want to see the doctor. EMS found the resident competent so when she refused treatment they left. When the officer

asked why she wasn't taking her medications, she said she didn't need them. She finally decided to accompany the ALF tech to the hospital to see the doctor. Does she fall under the Baker Act guidelines for law enforcement purposes?

People have the right to refuse medications or any kind of medical intervention as long as they have the capacity of making their own decisions. Just because this woman lives in an ALF doesn't change her right to refuse. In the absence of any apparent mental illness, the Baker Act is an inappropriate intervention for her. If the ALF believed her to be suffering from self-neglect, the staff could report her to the Abuse Registry for DCF Adult Protective Investigators to determine whether voluntary or involuntary intervention under chapter 415, FS is warranted. If she lacks capacity to make such decisions for herself, DCF could have her examined and, if necessary, get a court order for treatment.

ALF's aren't medical facilities like nursing homes. They often don't have regular, much less immediate access to physicians or other health care professionals. As a result, the woman's refusal to take prescribed medications required to maintain her life and health could result in her being discharged from the ALF. It sounds like the ALF did the right thing in finding ways to encourage her to visit her physician – hopefully this resulted in her agreement to take the medications and avoid a transfer.

In any case, your officer's decision to avoid the Baker Act was probably correct. Given her right to refuse medications and the finding by EMS that she had the capacity to make such decisions, this doesn't seem to be appropriate for the Baker Act. Further, she had no diagnosis of mental illness and it's a medical issue as to whether missing her blood pressure and diabetes medication for two days constitutes a real, present, and substantial harm to her well-being. Agitation doesn't necessarily cause serious bodily harm to herself or others. The criteria doesn't appear to be met.

Q. Are nursing homes and long term care facilities allowed to send a resident to the emergency room for combative, aggressive and agitated behaviors per request of the primary care physician/practitioner per telephone order without initiating the Baker Act? This question relates to patients/residents that are over 60 years old and have memory loss and dementia and are not able to make an informed decision.

A long-term care resident cannot be sent to a hospital or receiving facility for psychiatric issues without fully complying with the voluntary, involuntary and transport provisions of the Baker Act, per chapters 400/429.

> **400.102** Action by agency against licensee; grounds.--In addition to the grounds listed in part II of chapter 408, any of the following conditions shall be grounds for action by the agency against a licensee:
> (3) Failure to follow the criteria and procedures provided under part I of chapter 394 relating to the transportation, voluntary admission, and involuntary examination of a nursing home resident;
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> **429.14** Administrative penalties.--
> (1) In addition to the requirements of part II of chapter 408, the agency may deny, revoke, and suspend any license issued under this part and impose an administrative fine in the manner provided in chapter 120 against a licensee of an

assisted living facility for a violation of any provision of this part, part II of chapter 408, or applicable rules, or for any of the following actions by a licensee of an assisted living facility, for the actions of any person subject to level 2 background screening under s. 408.809, or for the actions of any facility employee:
(d) Failure to follow the criteria and procedures provided under part I of chapter 394 relating to the transportation, voluntary admission, and involuntary examination of a facility resident.

394.4625 Voluntary admissions.--
(1) AUTHORITY TO RECEIVE PATIENTS.--
(b) A mental health overlay program or a mobile crisis response service or a licensed professional who is authorized to initiate an involuntary examination pursuant to s. 394.463 and is employed by a community mental health center or clinic must, pursuant to district procedure approved by the respective district administrator, conduct an initial assessment of the ability of the following persons to give express and informed consent to treatment before such persons may be admitted voluntarily:
1. A person 60 years of age or older for whom transfer is being sought from a nursing home, assisted living facility, adult day care center, or adult family-care home, when such person has been diagnosed as suffering from dementia.
2. A person 60 years of age or older for whom transfer is being sought from a nursing home pursuant to s. 400.0255(12).
3. A person for whom all decisions concerning medical treatment are currently being lawfully made by the health care surrogate or proxy designated under chapter 765.
(c) When an initial assessment of the ability of a person to give express and informed consent to treatment is required under this section, and a mobile crisis response service does not respond to the request for an assessment within 2 hours after the request is made or informs the requesting facility that it will not be able to respond within 2 hours after the request is made, the requesting facility may arrange for assessment by any licensed professional authorized to initiate an involuntary examination pursuant to s. 394.463 who is not employed by or under contract with, and does not have a financial interest in, either the facility initiating the transfer or the receiving facility to which the transfer may be made.

Generally, persons will never be sent appropriately on a voluntary basis from nursing homes or other long-term care facilities because these residents are typically unable to make “well-reasoned, willful and knowing decisions about their medical and health care” – the very definition of competence to consent to admission and treatment under the Baker Act.

394.463(2) Involuntary examination.--
(b) A person shall not be removed from any program or residential placement licensed under chapter 400 or chapter 429 and transported to a receiving facility for involuntary examination unless an ex parte order, a professional certificate, or a law enforcement officer's report is first prepared. If the condition of the person is such that preparation of a law enforcement officer's report is not practicable before removal, the report shall be completed as soon as possible after removal, but in any case before the person is transported to a receiving facility. A receiving facility admitting a person for involuntary examination who is not accompanied by the required ex parte order, professional certificate, or law enforcement officer's

report shall notify the Agency for Health Care Administration of such admission by certified mail no later than the next working day...

A physician or authorized mental health professional must reach his or her conclusion that the person meets the criteria based on his/her own observations – not the statements of others. A telephone call, absent the physician's own examination, would not suffice.

However, if the long-term care facility physician believes the person to have an emergency medical condition that is the basis of the symptoms, referral to an ER may be appropriate. However, once the emergency medical condition has been determined to be stabilized or not to exist, the resident should be returned to his/her home at the long-term care facility. If the resident is then still in need of psychiatric examination or short-term psychiatric treatment, the resident could be sent to a receiving facility after full compliance with the Baker Act. Should the resident need specialized long-term care, the sending facility should arrange a direct referral to such a specialized facility rather than initiating voluntary or involuntary examinations through the Baker Act.

Q. If someone in a long-term facility is acting in a manner that appears to be related to mental illness and this behavior is escalating, what should be done?

First there should be an assessment done by the facility to determine if something in the person's environment may be causing this behavior and steps taken to alleviate the circumstances. If this fails, then consultation should be requested, i.e., psychiatrist, physician, psychologist, social worker, mental health worker, case manager, mental health coordinator in a licensed limited mental health assisted living facility, etc., as appropriate. All appropriate attempts to address the problem by providing care should be taken on-site prior to transfer and documented.

The long-term care facility should refer to the Quality First Credentialing Program Best Practice Tool developed by the Florida Health Care Association titled "Behavior Management / Aggression Control / Involuntary Baker Act Guidelines" dated 3/27/07.

Q. Are Baker Act receiving facilities equipped to treat behavior problems of person with dementia and Alzheimer's disease?

Receiving facilities are designated by DCF to perform psychiatric examinations and short-term psychiatric treatment. If the resident does not have a mental illness (as defined in the law) and would not benefit from short-term treatment, they should not be sent to a receiving facility. Instead, a transfer should be negotiated with another nursing home that has the capability of meeting the resident's needs. Baker Act receiving facilities are not a discharge destination – only a temporary setting in which short-term psychiatric treatment can be provided.

Q. How can staff of a long-term care facility prevent harm to staff or other residents by a person with severe behavior problems?

Nursing and social work staff should work with skilled consultants when necessary, at the first sign of behavior problems. Interventions, including behavior management, medications, redirection, comfort measures, change of rooms, one-to-one, revisions to plan of care, and other services are often successful. Choices are not limited to picking between the Baker Act and allowing staff/residents to be harmed. A policy and procedure for working with behavioral problems of residents has been developed by the Florida Health Care Association Quality Credentialing Foundation. The tool is titled "Behavior Management/Aggression Control (Involuntary Baker Act Guide). Use of this recommended Best Practice Tool will prevent many unnecessary transfers and improve quality care in nursing facilities.

Voluntary Admission

Q. Why is there a special independent evaluation required of certain people in long-term care facilities before they can be sent to a facility for psychiatric examination or treatment unless an involuntary examination is first initiated?

The Florida Legislature made major revisions to the Baker Act in 1996 as a result of some nursing homes and ALF's around the state sending very frail elders to a couple of psychiatric hospitals in Pinellas and getting kickbacks in return. These elders lacked capacity to provide express and informed consent to the admissions. Some of them died as a direct result of the transfers. The following is the provision of the Baker Act governing voluntary admissions:

> **394.4625** Voluntary admissions.--
> (1) AUTHORITY TO RECEIVE PATIENTS.--
> (a) A facility may receive for observation, diagnosis, or treatment any person 18 years of age or older making application by express and informed consent for admission or any person age 17 or under for whom such application is made by his or her guardian. If found to show evidence of mental illness, to be competent to provide express and informed consent, and to be suitable for treatment, such person 18 years of age or older may be admitted to the facility. A person age 17 or under may be admitted only after a hearing to verify the voluntariness of the consent.
> (b) A mental health overlay program or a mobile crisis response service or a licensed professional who is authorized to initiate an involuntary examination pursuant to s. 394.463 and is employed by a community mental health center or clinic must, pursuant to district procedure approved by the respective district administrator, conduct an initial assessment of the ability of the following persons to give express and informed consent to treatment before such persons may be admitted voluntarily:
> 1. A person 60 years of age or older for whom transfer is being sought from a nursing home, assisted living facility, adult day care center, or adult family-care home, when such person has been diagnosed as suffering from dementia.
> 2. A person 60 years of age or older for whom transfer is being sought from a nursing home pursuant to s. 400.0255(12).
> 3. A person for whom all decisions concerning medical treatment are currently being lawfully made by the health care surrogate or proxy designated under chapter 765.

(c) When an initial assessment of the ability of a person to give express and informed consent to treatment is required under this section, and a mobile crisis response service does not respond to the request for an assessment within 2 hours after the request is made or informs the requesting facility that it will not be able to respond within 2 hours after the request is made, the requesting facility may arrange for assessment by any licensed professional authorized to initiate an involuntary examination pursuant to s. 394.463 who is not employed by or under contract with, and does not have a financial interest in, either the facility initiating the transfer or the receiving facility to which the transfer may be made.
(d) A facility may not admit as a voluntary patient a person who has been adjudicated incapacitated, unless the condition of incapacity has been judicially removed. If a facility admits as a voluntary patient a person who is later determined to have been adjudicated incapacitated, and the condition of incapacity had not been removed by the time of the admission, the facility must either discharge the patient or transfer the patient to involuntary status.
(e) The health care surrogate or proxy of a voluntary patient may not consent to the provision of mental health treatment for the patient. A voluntary patient who is unwilling or unable to provide express and informed consent to mental health treatment must either be discharged or transferred to involuntary status.
(f) Within 24 hours after admission of a voluntary patient, the admitting physician shall document in the patient's clinical record that the patient is able to give express and informed consent for admission. If the patient is not able to give express and informed consent for admission, the facility shall either discharge the patient or transfer the patient to involuntary status pursuant to subsection (5).

The terms “express and informed consent” as well as “incompetent to consent” are specifically defined in the law, as follows;
(9) "Express and informed consent" means consent voluntarily given in writing, by a competent person, after sufficient explanation and disclosure of the subject matter involved to enable the person to make a knowing and willful decision without any element of force, fraud, deceit, duress, or other form of constraint or coercion.
(15) "Incompetent to consent to treatment" means that a person's judgment is so affected by his or her mental illness that the person lacks the capacity to make a well-reasoned, willful, and knowing decision concerning his or her medical or mental health treatment.

This means that the ability of a person in a long-term care facility over the age of 60 to make well-reasoned decisions must be established by an independent professional prior to the person’s transfer. Nothing prohibits the initiation of an involuntary examination for these persons. Chapters 400 (nursing homes) and 429 (ALF’s) contain language that failure to comply with the voluntary, involuntary and transport provisions of the Baker Act is cause for action against the facility’s license.

Q. Which nursing home and ALF residents must have an independent assessment of their ability to provide express and informed consent prior to being sent to a hospital or receiving facility on a voluntary basis?

Baker Act governance of transfers of persons from facilities licensed under chapter 400 and 429 applies to all involuntary examinations. The elevated protections of persons sent on voluntary status is limited to:

1. A person 60 years of age or older for whom transfer is being sought from a nursing home, assisted living facility, adult day care center, or adult family-care home, when such person has been diagnosed as suffering from dementia.
2. A person 60 years of age or older for whom transfer is being sought from a nursing home pursuant to s. 400.0255(12).
3. A person for whom all decisions concerning medical treatment are currently being lawfully made by the health care surrogate or proxy designated under chapter 765.

Nursing homes should always have access to a physician or other authorized professional to initiate an involuntary examination. An ALF (since it is not subject to federal OBRA) could send residents on “voluntary” status unless they are at least 60 years of age and have a diagnosis of dementia or have a health care surrogate or proxy currently making health care decisions for them.

Q. Who does a long-term care facility or program call to get an assessment for voluntary Baker Act admissions?

The Department of Children and Family Services’ Circuit mental health program office will direct the facility or program to the appropriate resource, in accordance with a plan approved by that district administrator.

Q. If DCF doesn’t have a state funded service to perform the independent assessment of persons from long-term care facilities, the law requires that the assessment be completed by an independent professional who is not employed by or under contract with, and does not have a financial interest in, either the facility initiating the transfer or the Baker Act receiving facility to which the transfer may be made. Does this requirement only apply to voluntary admissions? Who pays for the assessment?

This section of law applies only to voluntary admissions. An involuntary examination can be initiated by an authorized mental health professional employed or under contract at the facility. This heightened protection of "voluntary" admissions was intended by the Legislature to keep facilities from sending everyone as voluntary, when it is clear that the resident can't give well-reasoned, willful, and knowing decisions about his/her care -- the definition of competence to consent. The issue of who pays for this independent professional assessment is not addressed in the law or appropriations' act. Medicare, Medicaid, private insurance, or self-pay may all be considered. This provision will rarely be needed since most long-term care residents who require inpatient psychiatric care will not meet the definition of competence, i.e. being able to make well-reasoned, willful and knowing decisions about medical or mental health care.

Q. Does the long-term care facility have to have an independent mental health professional conduct an evaluation prior to an authorized professional connected with the facility initiating an involuntary examination?

NO. The independent assessment required under the Baker Act is limited to voluntary admissions. An authorized mental health professional associated with the facility who has personally examined the person within 48 hours of signing the Certificate and whose observations are consistent with the criteria for involuntary examination is authorized, without independent corroboration, to initiate an involuntary examination

Q. I know it is the nursing home / ALF's responsibility to arrange an independent assessment of a resident's competency to provide express and informed consent to treatment prior to their voluntary transfer. Chapter 400.102(1)(c) states "Any of the following conditions shall be grounds for action by the agency against a licensee: (c) Failure to follow the criteria and procedures provided under part I of chapter 394 relating to the transportation, voluntary admission, and involuntary examination of a nursing home resident;" There is even a "Recommended Form" CF-MH 3119 for reporting non-compliance to the agency. Where does it say that the receiving facility is responsible for reporting non-compliance to the agency?

394.463(2)(b), FS states: A person shall not be removed from any program or residential placement licensed under chapter 400 and transported to a receiving facility for involuntary examination unless an ex parte order, a professional certificate, or a law enforcement officer's report is first prepared. If the condition of the person is such that preparation of a law enforcement officer's report is not practicable before removal, the report shall be completed as soon as possible after removal, but in any case before the person is transported to a receiving facility.

A receiving facility admitting a person for involuntary examination who is not accompanied by the required ex parte order, professional certificate, or law enforcement officer's report shall notify the Agency for Health Care Administration of such admission by certified mail no later than the next working day. The provisions of this paragraph do not apply when transportation is provided by the patient's family or guardian.

A nursing home cannot perform the competency assessment for voluntary admission. It must be performed by an independent assessor that isn't employed by, under contract with, or having any financial interest in either the nursing home or the receiving facility, assuming that a publicly funded service designated by DCF for this purpose isn't available to do the assessment. A person must be under a voluntary or involuntary status – there isn't anything in between. If there isn't documentation that a nursing home resident has had a voluntary admission properly initiated, including the independent assessment of competency, it is presumed that it must be an involuntary examination. In such cases, the Baker Act is clear that the receiving facility is the responsible party for reporting the nursing homes that fail to follow the law. While the reporting form is "recommended", the reporting itself within one working day by certified mail is mandatory. While the recommended form has been determined to meet the statutory requirements for reporting, a receiving facility may alter the form.

Q. What if the voluntary assessment of a long-term care facility resident cannot be done in a reasonable amount of time?

When a voluntary assessment program is not available or it cannot be done within two hours after the request is made the requesting facility may arrange for assessment by any physician, clinical psychologist, clinical social worker, or psychiatric nurse (each as defined in the Baker Act), who is not employed by or under contract with, and does not have a financial interest in, either the facility initiating the transfer or the receiving facility to which the transfer may be made.

Q. If it is determined by the long-term care facility that the person does not have the capacity to consent to voluntary treatment, what should be done?

If the person doing the assessment does not complete a professional's certificate for involuntary examination, the facility has the following options:

a. The facility may get a mental health professional (a licensed clinical psychologist, a physician, a licensed clinical social worker, or a psychiatric nurse, as defined in section 394.455, F.S.), to initiate a professional certificate for involuntary examination (CF-MH 3052b). At that time, law enforcement will transport the person to the nearest designated receiving facility; or Section 394.462(1)(k), F.S. provides for an exception to transportation by law enforcement when a county has entered into a contract with a transport service. However, the law enforcement officer and the transport service representative must first agree that the continued presence of law enforcement personnel is not necessary for the safety of the person or others. Preference for this transportation service for persons in nursing homes, assisted living facilities, adult day care centers, or adult family-care homes shall be given unless the behavior of the person is such that law enforcement is necessary; or

b. Law enforcement may initiate an involuntary examination; however, they must have reason to believe that the person is a danger to themselves or others or be unable to care for self; or

c. The circuit court may be petitioned for an ex parte order for involuntary examination.

Involuntary Examination

Q. Our AHCA office has received complaints regarding Baker Act violations at an assisted living facility and a nursing home. Although the facilities are different, the circumstances are very similar. In both cases, a resident was acting out and expressing suicidal ideations. Each facility called emergency services and the residents were transported to the hospital ER. Once in the ER, the physician there initiated the involuntary examination and the residents were transferred to the psychiatric unit. Why wouldn't the ALF & the nursing home initiate the involuntary examination while the resident was still at their facilities? Is it a violation for the facility to transfer the resident to the ER first for assessment and then the ER to initiate the BA? The psychiatrist for this facility called and was irate that they should be cited, says the resident had an "altered mental state".

Your citation of the nursing home is fully consistent with law. A nursing home can only send someone to a receiving facility or hospital for behavioral or psychiatric purposes under the voluntary or involuntary provisions of the Baker Act. Clearly, the resident did not have an independent evaluation of his/her ability to give express and informed consent to the transfer; therefore this wasn't voluntary. Neither did the facility have a physician, psychiatrist, psychologist, social worker, mental health counselor, marriage and family therapist, or psychiatric nurse come to the facility to do an on-site examination of the resident and initiate an involuntary examination. Law enforcement officers weren't called to either transport or defer transport to a medical transportation firm.

> Chapter 400.102 Action by agency against licensee; grounds.--
> (1) Any of the following conditions shall be grounds for action by the agency against a licensee:
> (a) An intentional or negligent act materially affecting the health or safety of residents of the facility;
> (b) Misappropriation or conversion of the property of a resident of the facility;
> **(c) Failure to follow the criteria and procedures provided under part I of chapter 394 relating to the transportation, voluntary admission, and involuntary examination of a nursing home resident;**

This might also be a violation of the federal OBRA law requiring the specialized needs of nursing home residents be met in place whenever possible. The Florida Health Care Association developed a model policy and procedure to assist its members in meeting the needs of residents with severe behavioral problems consistent with federal and state laws. While there may be extraordinary occasions when nursing home residents require transfer to a Baker Act receiving facility, it should only be after all less intrusive alternatives have been ruled out and justified that the services expected to be delivered at the receiving facility can't be offered at the nursing facility. Many nursing homes are alleging "altered mental state" as a rationale for avoiding the Baker Act involuntary examination. It is difficult to determine how the psychiatrist could have alleged this if he/she hadn't examined the person. Since the purpose of transfer in such cases is for medical rather than for behavioral reasons, the ER physician will probably just rule out a stroke or other medical reason and immediately return the resident to the facility where staff can then initiate the involuntary examination if they believe the person's behavior is a result of mental illness. The ER physician has no legal duty to initiate the involuntary examination under the Baker Act, especially when the nursing home staff didn't believe the behavior was due to mental illness.

Q. Does a nursing home administrator have the authority to initiate a Baker Act on a resident with Alzheimer\'s Disease receiving hospice care?

A nursing home administrator does not have the authority to initiate an involuntary examination on a resident unless that administrator is also a physician, clinical psychologist, LCSW, LMHC, LMFT, or a psychiatric nurse (Master's degree in psychiatric nursing).

The facility can't send a resident on voluntary status unless there is an assessment of the resident's capacity to make well reasoned, willful and knowing medical and mental health decisions. The assessment can only be done by a licensed professional (one of

those listed above) who isn't employed by, under contract with, or has a financial interest in either the nursing home or the facility to which the resident is to be sent.

The question is why is the resident being sent? A Baker Act facility is only for the purpose of psychiatric examination and short-term psychiatric treatment. This can usually be done in place as required by the federal OBRA law and chapter 400, FS. A Baker Act receiving facility isn't a destination and the nursing home remains responsible for providing legally required notices and in either accepting the resident back or to provide adequate discharge planning to a facility where the resident's needs can be met.

Chapter 400, FS states that failure by a nursing home to follow the voluntary, involuntary and transport provisions of the Baker Act (394, Part I) must be reported by certified mail within one working day by a receiving facility and can result in action against the nursing home's license.

Q. Many residents are not able to care for themselves, and that is a primary reason they are in the nursing facility. Some of them become adamant about leaving the facility without a realistic and safe discharge plan. Usually this would be AMA. This is when I get calls to assess for involuntary examination. Is it appropriate to Baker Act them simply to prevent them from leaving the facility?

No – it is not appropriate to initiate an involuntary psychiatric examination to keep a person from leaving a nursing home. A person has a right to stay or leave a nursing home unless a court-appointed guardian has determined it necessary for the person to remain. An involuntary examination is only for the purpose of obtaining a psychiatric exam or short-term psychiatric treatment and only because a person has a mental illness as defined in the Baker Act, and because of the mental illness has refused or is unable to consent to an exam and is actively or passively dangerous.

Insistence on leaving a nursing facility wouldn't alone meet these criteria a facility. Threatening such action solely due to a resident's expressed intent to leave would be inappropriate.

Q. What should happen to a long-term care facility resident when the nearest receiving facility is at capacity and not accepting new admissions?

A receiving facility must "accept" any person brought by law enforcement for involuntary examination. If at capacity, the receiving facility must contact other facilities in the community to find one with the capability and capacity to serve the person, and initiate a transfer. If EMS has been delegated responsibility by law enforcement via use of the 3100 form, the receiving facility is required to accept the person if presented by law enforcement. If the receiving facility is a licensed hospital (not a CSU) it must accept the person regardless of who provides transportation, if the person has an emergency psychiatric condition, (EMTALA). If receiving facilities are refusing to accept persons for involuntary examinations, complaints should be made with AHCA and DCF staff.

Q. Is there a preference as to which of the three methods of initiating an involuntary examination, e.g. Judge, law enforcement, or professional should be used for residents of long-term care facilities?

YES. One of the authorized mental health professionals (as defined in the Baker Act) including:

- Psychiatrist
- Physician
- Clinical Psychologist
- Licensed Clinical Social Worker
- Licensed Mental Health Counselor
- Licensed Marriage & Family Therapist
- Psychiatric Nurse

who is either employed by or under contract with the facility should always be the first option to initiate the involuntary examination. This professional has the training and experience to evaluate the resident's condition and determine if a consultation by a specialist would avoid the necessity of the transfer. It is essential that the Certificate form be fully completed. Only in the case of a true emergency should a law enforcement officer be expected to act for the professional associated with the facility. If neither the authorized professional associated with the facility or a law enforcement officer has seen behavior consistent with the involuntary examination criteria and a law enforcement officer doesn't believe the criteria has been met, staff who have seen such behavior should go to the probate office of the court and file a petition for an ex parte order.

Q. Can a long-term care facility resident's family refuse to have the resident transferred to a receiving facility for an involuntary examination?

NO. Such initiation of an involuntary examination is solely vested in an authorized professional, judge, or law enforcement officer. Family members may request transfer of the person to a different receiving facility, once the person has been taken to the nearest receiving facility. However, the facility should listen carefully to the concerns raised by the family and consider whether their concerns could be addressed in an onsite evaluation, in order to avoid the possible problems to the resident that often result from transfers.

Q. We had a serious problem recently at our receiving facility when a nursing home resident was transferred to an ER (non-receiving facility) for behavioral problems without first initiating an involuntary examination. No apparent efforts were made to stabilize her condition at the nursing home. She has been referred to a CSU that has refused the transfer due to medical issues and has been in the ER for much longer than the 12 hours permitted by law after medical clearance. What can be done?

The nursing home shouldn't have sent the resident to the hospital for psychiatric issues unless it had completed the involuntary examination prior to the resident leaving the nursing home. He/she should have been sent directly to the nearest receiving facility unless she had an emergency medical condition. If the nursing home failed to do this, it is a cause for action against the nursing home's license and is required by law to be reported to AHCA by certified mail within one working day. The same violation would have occurred if they had sent her on "voluntary" status without the independent evaluation of the resident's ability to provide express and informed consent. The nursing

home should have taken significant measures to stabilize the resident in place, as described by the Florida Health Care Assn. model policy and procedure. This would ensure the nursing home was in compliance with the federal OBRA law requiring it to meet the specialized needs of its residents.

The 72-hour clock would have been ticking ever since the physician found her to be medically stable. It is a person's right not to be held longer than 72 hours for psychiatric examination, not for a facility to have 72 hours in which to perform such an exam. Neither however, is it acceptable to release a person without the psychiatric examination being done that he or she was referred for, especially when it appears she actually meets criteria. The sending hospital should have reported to AHCA and DCF that it was unable to transfer the person within the 12 hours permitted under the law, assuming that sending hospital is not a designated receiving facility. Even if a person has been determined "medically clear" by a hospital's physician, the person's condition may require more medical care than can be reasonably expected from a free-standing, non-hospital, psychiatric facility.

Q. I am a coordinator of our CSU. A local nursing home occasionally Baker Acts their patients that they consider behavior issues by stating that they do not have a doctor on premises to evaluate the patient or offer behavior modification techniques. They then call law enforcement to initiate the involuntary examination by reporting the resident is a danger to self or others. The most recent case was of a 67 year old man with Alzheimer's and Parkinson's who was refusing his medications, threw a wheelchair, and was trying to choke himself. Staff said "he was so strong that I couldn't hold him down" and "he wanted me to kill him". He was admitted to this facility for about 15 hours during which time he was calm, cooperative, did not appear to have a/v hallucinations and denied h/s ideations, took his medications, but had memory problems as expected. The psychiatrist evaluated the patient, found that he did not meet Baker Act criteria, and wrote the discharge order. At first the nursing home refused to accept him back, but after I explained AHCA's requirements, they told me to send him back. Were we or the nursing home wrong?

Residents of nursing homes are protected by the federal OBRA law and chapter 400, FS. OBRA requires that the specialized needs of residents be met in place, instead of transferring them out of the facility. What is done by a receiving facility is most often nothing more than what can be done under the care of a consulting psychiatrist at the nursing home. Each nursing home has a physician under contract who should be addressing the needs of residents. If the physician refuses to meet his/her obligation to the facility residents, the contract should be cancelled and AHCA should be notified.

A physician is only one of the many mental health professionals authorized in the Baker Act to initiate an involuntary examination. A psychologist, psychiatric nurse, clinical social worker, marriage and family therapist, and mental health counselor can also initiate. If the nursing home has access to none of these, staff who saw the behavior can go to the Clerk of Court's office and fill out a sworn affidavit seeking an ex parte order of the court. Only in situations of imminent danger that couldn't be avoided by more appropriate action by the nursing home staff would calling law enforcement be appropriate. Law enforcement "shall" initiate the involuntary examination only if he/she believes the resident to meet each and every criteria – not just "dangerous to self and

others". Officers should be encouraged to report to AHCA any facilities that are misusing law enforcement to do what should be the nursing home's responsibility.

A model policy and procedure developed by the Florida Health Care Association for its members to use in caring for residents with behavioral health issues is available in Appendix E of the 2008 Baker Act Handbook (see DCF website). Baker Act isn't even mentioned until the middle part of page 3 of a 4-page document. Baker Act should only be used when all other alternatives have proven to be unsuccessful. It should never be used for staff convenience or simply to transfer the cost of care from the nursing home to another facility.

When an involuntary examination is appropriate and unavoidable, the receiving facility's obligation is to provide a physician or psychologist to conduct an examination – admission is not required. In fact, if the man didn't meet criteria, you did the absolute right thing in returning the man to his home as quickly as possible. It sounds as if everything you did for the man could have been done at the nursing home. A Baker Act receiving facility isn't a discharge destination – it is only for psychiatric examination and short-term treatment You would probably want to report to AHCA any refusal to take a resident back to the nursing home because this will probably be cited as a failure to conduct appropriate discharge planning.

You are correct that these transfers are often the result of unaddressed pain, infection and other medical conditions, medication interactions, etc. They can also result from untrained staff at the nursing home. The only thing that may keep this from happening again is to involve AHCA staff to review the nursing home's capability to manage the specialize needs of its residents.

Q. I have question on "determination that person does not meet involuntary placement". An involuntary examination form was completed at a nursing home and the resident was sent to our hospital ER for medical clearance. Once cleared by our ER physician, we were unable to transfer. As a result, we have to admit the person to a medical floor on an inpatient basis. The attending physician states the patient is not medically cleared for psychiatry. How long do we continue to wait for clearance? Can the attending physician determine that person does not meet involuntary placement and complete the appropriate form? Is the nursing home held accountable to accept patient back?

Your hospital has just 12 hours to transfer a person under involuntary examination criteria after a physician determines the emergency medical condition (EMC) (as defined in 395.002, FS) is stabilized or found not to exist. There is no maximum length of time for the EMC – some may be stabilized in an hour while others may take weeks. This presumes that a person can't be psychiatrically examined while an emergency medical condition exists. However, an emergency medical condition and having medical issues may be two entirely different situations. Just having medical issues wouldn't be legally sufficient to warrant depriving a person of liberty. If the physician is holding the person longer than 12 hours past the stabilization of an emergency medical condition, you should contact hospital administration to discuss the potential liability. The attending physician at a hospital examining/treating an emergency medical condition is authorized to conduct the involuntary examination and release the person (or convert to voluntary status) if the person doesn't meet involuntary placement criteria.

Long-term care facilities must understand that the Baker Act cannot be used to avoid their federal and state obligations to do adequate discharge planning for residents who cannot be served in their facilities. Hospital ER's and Baker Act receiving facilities are NOT discharge destinations – they are merely facilities to which long-term care residents meeting certain criteria can be transferred for purposes of examination and treatment of acute care conditions. The nursing home should be reported to AHCA and it is likely to be cited for failure to conduct legally required discharge planning as have other SNF's in the state.

Transportation

Q. Is law enforcement transportation required to take a resident of a nursing home or ALF to a receiving facility for involuntary examination?

YES. The law requires that law enforcement be contacted and that they respond. If the law enforcement officer determines for the safety of the officer or the resident, that assistance from emergency medical personnel is needed, the officer can authorize EMS to provide the transport. The officer is required to complete the CF-MH 3100 form titled "Transportation to a Receiving Facility", leaving the designated portions of the form to be completed by EMS personnel. The transportation form, along with one of the three documents initiating the involuntary examination, must accompany the resident to the receiving facility.

Q. Is a long-term care facility permitted to allow family members or guardians to transport a person for involuntary examination?

The law only references law enforcement transportation, unless the officer determines that emergency medical personnel are needed. Since the resident has been determined, by virtue of the criteria for involuntary examination, to have refused or be unable to consent to the examination and to be subject to self-neglect or overt harm to self/others, facilities should consult with legal counsel about liability issues if persons other than law enforcement are authorized to transport.

Q. What choices does a long-term care facility have when law enforcement refuses to transport?

If law enforcement refuses to respond to the facility's request for transporting a resident for whom an involuntary examination has been initiated, it is recommended that the facility administrator contact the supervisor of the officer refusing to respond. If the supervisor doesn't assist, ask to speak with the attorney for the law enforcement agency. If none of these options result in law enforcement response, the facility should contact the Circuit DCF mental health program office and or the AHCA field office. If it occurs at night or on a weekend, and none of the above is available and the need for transfer is urgent, the facility should seek EMS assistance to transport the resident to the nearest receiving facility. On the next working day, the facility should contact DCF and AHCA to seek long-term resolution of this problem.

Q. Can nursing homes transport a resident who is stable enough and is in agreement to go for treatment?

A person who is able to give well-reasoned decision-making and understands the purpose of and is willing to go to a receiving facility meets the criteria for voluntary examination (cannot be a person who has been adjudicated incapacitated or who has a Health Care Surrogate or Proxy currently making decisions for them). In such cases, an independent assessment of the resident's capacity to make such decisions is required before transfer.

Q. Must a resident of a long-term care facility always be transported to the nearest receiving facility?

a. If a person is to be treated voluntarily and has been determined by the statutorily required independent assessment to have the capacity to consent to treatment, the person may be transported to the facility of his/her choice.
b. If the person is transported on an involuntary basis by law enforcement or a county contracted emergency medical transport service, the person must be taken to the nearest receiving facility.
c. A person who is involuntary and is personally driven by a family member or guardian does not have to go to the nearest receiving facility (not recommended).
d. Section 394.462(3), F.S., provides for exceptions to transportation requirements if there is a district plan approved by the Board of County Commissioners and the Secretary of the Department of Children and Families.

Transfers

Q. I'm a Long-Term Care Ombudsman and need to ask about the way a Baker Act was handled. A resident was sent to a third ALF after the one she was residing in was closed because of bedbugs. She had a traumatic brain injury a few years ago, hallucinates and has some distressing personal behaviors. The ALF where she was dumped quickly realized that she was inappropriate for their facility and wanted her out immediately but did little to help make that happen. Finally, the resident's doctor was contacted by the mother and his staff said he might admit her to the hospital for a few days and then place her, promising to keep the mother notified. When the mother called the ALF to speak with resident she was told that she was Baker Acted and they told mother the room number. Repeated calls by the mother to all receiving facilities (all denied having her) and a report to law enforcement were made as well as a report to the Abuse Registry. Three days later she found out her daughter had been admitted to and remained at one of the receiving facilities she had called. There is no legal guardian, but mother has been actively representing her since the accident 6-7 years ago. Is this because of Baker Act laws? HIPAA?

AHCA should be consulted about the ALF role in accepting a referral without assessment of appropriateness. Being bumped from one ALF to another is sure to contribute to an individual's instability and confusion, as well as behavioral issues.

Failure to inform next of kin of a transfer may also be an issue. Under certain circumstances, a resident of an ALF has elevated protections under the Baker Act.

If the resident was age 60 or older with any type of dementia, the Baker Act would have required that the facility either arrange for the involuntary examination to be initiated before sending to a receiving facility or having an independent professional assess the individual's competency to provide express and informed consent prior to the transfer. These requirements would also apply if the resident had a health care surrogate or proxy making her medical or mental health decisions. However, if not age 60 or if no health care surrogate/proxy exists, this requirement would not apply.

You mention that the resident's mother has been "actively representing her" for the last few years. If this is in the role of health care proxy because a physician has determined that she can't make informed health care decisions for herself, she cannot be admitted on voluntary status under the Baker Act. She would have to be held under involuntary status where her mother as her health care proxy would be authorized to make her medical and mental health treatment decisions. The Proxy could make treatment decisions, but not admission decisions on behalf of her daughter.

If the mother serves as her health care proxy, she would have the authority to access clinical information, release, such information, apply for transfers to other facilities, and to apply for public benefits on her daughters behalf. This is authorized under chapter 765, FS, Florida's Advance Directive statute. The federal HIPAA law defers to substitute decision-makers established by laws in each state as to who can access health information. A health care surrogate or proxy, guardian, guardian advocate, and durable health care power of attorney would be among those authorized in Florida.

It would never be appropriate to send a person under a Baker Act involuntary examination status to a non-receiving facility hospital unless the resident was believed to have an emergency medical condition. As the hospital where she was initially sent isn't a Baker Act receiving facility, it doesn't have the capacity or capability to meet specialized psychiatric needs of individuals with acute symptoms. If meeting the criteria for involuntary examination, the person was required to be sent to the nearest designated receiving facility to her residence.

Q. Regarding nursing homes and ALF's, I believe the attending physician at the facility should evaluate with a mental health examination (and not BA for behavioral issues), instead of just calling law enforcement to transfer to nearest facility. Am I understanding this correctly? Should the nursing home/ALF re-evaluate the resident after the Baker Act evaluation is completed to determine if the member is appropriate for return to their residence? To clarify, is the intent for the discharge CM or Utilization Review team to consult with the ALF/NH on the results of the in-hospital evaluation and together devise a plan for re-entry or transfer to an alternate level of care/NH/ALF?

The federal OBRA law requires that nursing home residents have their specialized needs met "in place" whenever possible. In such situations, a licensed mental health professional (physician, psychiatrist, psychologist, psychiatric nurse, LCSW, LMHC, or LMFT) should evaluate the resident for purposes of initiating an involuntary examination if the resident's condiltion appears to be psychiatric/behavioral instead of medical. A

voluntary transfer can only be done if one of the above professionals (totally independent of the sending or accepting facility) has certified the resident is capable of making well-reasoned, willing and knowing decisions about his/her medical and mental health care. Once an involuntary examination is appropriately initiated, law enforcement should be contacted to provide transport to the nearest receiving facility or to agree that continued presence of law enforcement is not needed for the safety of the resident or others, allowing for medical transport to be used instead.

If a resident is sent out for psychiatric examination or short-term psychiatric treatment that can't be provided at the facility, the resident should be able to return to his "home" once that exam or treatment is rendered, just as he/she would be for any other medical intervention. However, any decision made by the nursing home to not accept the resident back should be based on a re-evaluation of the resident's needs and if unable to return "home", the nursing home must provide notice of rights and develop an appropriate discharge plan. If the original intention of the nursing home was discharge the resident because it couldn't provide for the resident's needs, it has the obligation to find another nursing home that does have the capability of meeting the resident's needs – not do a "Baker Act" with the thought that this would meet its obligations under federal and state laws.

Q. What about the long-term care facility resident's personal effects and medical record when the person is transferred?

The sending facility should do an inventory of the person's personal effects such as eyeglasses, hearing aid, dentures, jewelry, etc. that will accompany the person or should be sent shortly thereafter. A copy of the medical record that shows current medications, dosages, frequencies, and allergies should accompany the person being transferred.

Q. Does a long-term care facility have to notify anyone about the person's transfer?

YES. Section 400.0255(7), F.S., requires nursing homes to notify the person's legal guardian or representative by telephone or in person before the transfer, or as soon thereafter as practicable, with documentation in the resident's file.

Q. Does a long-term care facility resident's health care surrogate or proxy have the authority to give permission to transfer the person to a psychiatric hospital?

NO. The health care surrogate does not have the authority to give permission to transfer a person, either voluntarily or involuntarily, to a psychiatric hospital.

Q. After residents are returned from the receiving facility to the nursing home or ALF, they are often so somnolent from new medications the behaviors are gone but the resident has declined in function. This apparent "over-medication" causes the facility staff to attempt a dosage reduction that often causes the psychiatric symptoms to escalate. What should the facility do?

Facility staff should not automatically attempt to reduce medications. They should keep the attending physician informed of the resident's condition, on a daily basis, if necessary, and follow doctor's orders. If the facility cannot meet the resident's mental health or medical needs, the resident should be transferred to another facility.

Refusal to Accept Back

Q. I am a Long-term Care Ombudsman and am attending a nursing home hearing tomorrow regarding a resident that was discharged by Baker Act, and the facility is refusing to readmit. The resident CAN NOT WALK, and has never exhibited threatening behavior prior. Is this right?

The Baker Act provides for psychiatric examination and short-term treatment. It is not a discharge destination any more than a hospital is for an acute medical condition. I believe that the federal OBRA law and Chapter 400, as well as case law, place the responsibility for an appropriate transfer clearly on the nursing home. If a nursing home is unable to provide the necessary care, it must find another appropriate facility that can. A Baker Act receiving facility is not such a facility. AHCA has cited nursing homes for failure to provide discharge planning in circumstances as you describe. I hope such a citation was made in the case you describe. This may be the only way the rights of these vulnerable residents are protected. All long-term care facility staff are urged to take the web-based course on Baker Act as it applies to such facilities. It is free and may help to reinforce critical learning. It is located at www.bakeracttraining.org

Q. What are the state and federal regulations that govern when a nursing home can decide NOT to take someone back after a Baker Act exam?

The federal law is called OBRA (Omnibus Budget Reconciliation Act) that was passed in the late 80's to ensure that people with special needs can have those needs met in place while residing in a nursing home. This means not sending them out for examination or treatment if it can be performed at the nursing facility. Chapter 400, FS picks up on OBRA issues and lays out the circumstances under which a person can be transferred or discharged by a nursing home without prior notice. In any case, a person still has the right to appeal the decision.

AHCA has taken the position that if a person is transferred / discharged from a nursing home for one reason and refused readmission for another reason, this is a violation of OBRA/400. If they are sent out for psychiatric examination/treatment but refused readmission because they are "dangerous", this could be a violation. The federal courts in an appellate case found this same thing. As you probably know, these same people who are refused readmission to the nursing home sending them out are subsequently placed in another nursing home that is licensed and staffed the same as the first one.

Q. Can a nursing home or ALF refuse to take a resident back after the resident has undergone examination and treatment at a receiving facility?

While a facility should not accept a resident back if their needs cannot be met, such a determination by the facility administration must be made in conjunction with the health

assessment conducted after examination and treatment at a receiving facility and clearly documented in the chart. Federal and state requirements for transfer and discharge must be observed, even under emergency conditions. Given that such residents will generally be transferred to another nursing home, licensed and staffed the same as the first nursing home, this may indicate the first facility should have been able to manage the residents condition.

Q. Is there any statute or case law that can assist my clients to get back to the nursing home or ALF after they are brought in for a Baker Act exam/commitment?

The federal OBRA law and chapter 400, FS govern transfer/discharge of persons from nursing homes. In addition, a Tennessee Court of Appeals case SMITH V. CHATTANOOGA MEDICAL INVESTORS, INC. (2001 WL 720494 (Tenn. Ct. App. 2001) said among other things that a nursing home could not refuse readmission to the resident on the grounds that he was dangerous and the court also pointed out that federal law sets forth transfer/discharge procedures, but that the nursing home had followed none of those procedures. Unfortunately, some of these issues might only be addressed by civil litigation against hospitals and nursing homes on behalf of persons who have been harmed. However, the Local Advocacy Council and/or Long-term Care Ombudsman Council in your area need to be aware of any facility violations, not to mention DCF and the Agency for Health Care Administration. Phone numbers for these groups in the "Where to Go for Help" appendix of the Baker Act Handbook.

Q. What happens to elderly clients in nursing homes who go to facilities for psychiatric treatment but are refused readmission back into the nursing home after discharge? Aren't facilities required to hold the bed? Is there a resource for the family and/or helping professional dealing with a case like this?

AHCA states that if a person is transferred or discharged from a nursing home for one reason and is refused readmission for another reason, this is de facto evidence of a federal OBRA violation.

Chapter 400, FS governs nursing homes, ALF's and other long-term care facilities. One part of this Florida law deals with emergency transfers, both of which require a physician's documentation in the resident's record, as follows: (7) At least 30 days prior to any proposed transfer or discharge, a facility must provide advance notice of the proposed transfer or discharge to the resident and, if known, to a family member or the resident's legal guardian or representative, except, in the following circumstances, the facility shall give notice as soon as practicable before the transfer or discharge:

> (a) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility, and the circumstances are documented in the resident's medical records by the resident's physician; or
>
> (b) The health or safety of other residents or facility employees would be endangered, and the circumstances are documented in the resident's medical records by the resident's physician or the medical director if the resident's physician is not available.

In cases of emergency transfer, notice "at the time of transfer" means that the family, surrogate, or representative are provided with written notification within 24 hours of the

transfer. The requirement is met if the resident's copy of the notice is sent with other papers accompanying the resident to the hospital. The federal and state laws have been written to protect the resident's right to age in place -- not to be transferred or discharged out of their home to another facility for the convenience of staff or for the facility to have more profits. In the situations you describe, the family (with your assistance) should make a complaint to AHCA and to the Long-term Care Ombudsman assigned to oversee the facility. The ombudsmen are volunteers appointed by the Governor to monitor long-term care facilities and to investigate complaints against the facilities. AHCA and the ombudsmen have an excellent track record in protecting resident rights.

Q. I am a social worker for a VA Hospital. We have a patient who was transferred from a nursing home. The nursing home is refusing to take the patient back. Is this correct? And, if so, what is the statute number?

Protection of nursing home residents is found in the federal OBRA law and chapter 400, FS. OBRA requires that nursing homes provide for the specialized needs of their residents in place, rather than transferring them to other settings, whenever possible. Chapter 400, FS further provides for these rights as follows:

> **400.022** Residents' rights.—
> (1)(p) The right to be transferred or discharged only for medical reasons or for the welfare of other residents, and the right to be given reasonable advance notice of no less than 30 days of any involuntary transfer or discharge, except in the case of an emergency as determined by a licensed professional on the staff of the nursing home,
>
> **400.0255** Resident transfer or discharge; requirements and procedures; hearings.--
> (2) Each facility licensed under this part must comply with subsection (9) and s. 400.022(1)(p) when deciding to discharge or transfer a resident.
> (3) When a discharge or transfer is initiated by the nursing home, the nursing home administrator employed by the nursing home that is discharging or transferring the resident, or an individual employed by the nursing home who is designated by the nursing home administrator to act on behalf of the administration, must sign the notice of discharge or transfer. Any notice indicating a medical reason for transfer or discharge must either be signed by the resident's attending physician or the medical director of the facility, or include an attached written order for the discharge or transfer. The notice or the order must be signed by the resident's physician, medical director, treating physician, nurse practitioner, or physician assistant.
>
> **400.102** Action by agency against licensee; grounds.--In addition to the grounds listed in part II of chapter 408, any of the following conditions shall be grounds for action by the agency against a licensee:
> (1) An intentional or negligent act materially affecting the health or safety of residents of the facility;
> (2) Misappropriation or conversion of the property of a resident of the facility;
> <u>(3) Failure to follow the criteria and procedures provided under part I of chapter 394 relating to the transportation, voluntary admission, and involuntary examination of a nursing home resident; or</u>

As far as court cases, a Tennessee appellate case in Smith v. Chattanooga Medical Investors found that

> "When the resident was ready to return from the hospital to the nursing facility, the nursing facility refused to admit him, claiming he was a 'dangerous patient' ... Finally, the court stated that the facility could not refuse readmission to the resident on the grounds that he was dangerous. The court pointed out that the federal law sets forth transfer/discharge procedures, including notice requirements, but that the nursing facility had followed none of these procedures".

The Florida Health Care Association has developed a model policy and procedure that lays out the practices a good nursing home will follow when faced with a resident with behavioral problems. You may wish to share that policy and procedure with the nursing home in question.

the DCF regional office on this reply so they can assist you in working with AHCA, the Long-term Care Ombudsman Committee, and the nursing home in meeting its obligations.

Q. We have a patient that was admitted from a nursing home. He refused to get out of the van at Dialysis and then refused to get out again when he got back to the facility. He then jumped out of the van and tried to break into a car across the street. The police came but didn't Baker Act him but brought him to the hospital. Now the nursing home is refusing to take him back. Can they do that to us? He is a bed hold at the facility. .

It appears that the man in question was not under the Baker Act. He was simply a medical patient transferred to you from a nursing home for dialysis. He would have the right to refuse any medical examination or medical treatment if he had the capacity to make such a decision. In the circumstances you describe, it is highly questionable as to whether or not he had such capacity and you would be well served to have his capacity assessed by a psychiatrist or psychologist. If he has capacity and is simply refusing unwanted medical treatment, he has the right to do this even if it has adverse outcomes. If he doesn't have such capacity, you may wish to work with your hospital's attorney about whether a referral under Adult Protective Services or directly to the circuit court under Probate Rule 5.900 would be appropriate.

Only in cases where the real, present and substantial self-neglect is due to mental illness can the Baker Act be considered. In such cases, only psychiatric examination and psychiatric treatment are governed by the Baker Act as Florida's mental health act. It doesn't provide for medical intervention.

Nursing homes are governed by the federal OBRA law and by chapter 400 Florida Statutes. The laws require nursing homes to provide for the specialized needs of their residents in-place whenever possible, transferring them to other facilities for these services when unable to be met on site. They are not required to keep a resident for whom they can't meet his or her needs, but they remain responsible for providing for an appropriate discharge of any resident they cannot retain.

You should work with your hospital administration to report this to the Agency for Health Care Administration as well as to the Long-Term Care Ombudsman Council serving your area of the state.

Q. A male resident of our nursing home was acting up and threatening to hit staff and other residents; he was totally out of control. The nurses called the Police, but they didn't want to Baker Act him but they ended up taking him to jail. Then the jail sent him to the hospital and the hospital Baker Acted him to our mental health facility. Is there some regulation that states that we have to accept him back in our facility?

Oversight of and investigations into nursing home practices are under the Agency for Health Care Administration and you would need to consult with AHCA about the impact of discharge decisions on your facility. The Baker Act is only for psychiatric examination and short-term psychiatric treatment – it isn't a destination. Given these disclaimers, the following information may assist you.

It is critical that a nursing home identify behavioral issues as soon as possible and to address them in the resident's care plan. Use of techniques that have worked for the resident in the past or ones your staff have found helpful can assist in retaining the resident and meeting his/her needs in-place. If the behavior came on in a gradual way, you have the opportunity to intervene with in-house and consulting experts to address the problems. If the behavior of an elder resident was of a sudden onset, experts tell me that these events often occur as a result of medical issues, particularly infection or pain. In any case, it should be your objective to meet the needs of the resident as soon as possible and retain or return the resident to your care whenever possible.

I've attached a copy of the model policy and procedure published by the Florida Health Care Association's Quality First Credentialing Program for dealing with persons who are aggressive and may need to be examined or treated for mental health conditions. This may help you in the future to prevent such situations or to intervene early enough to avoid use of law enforcement or the Baker Act. If you've followed the steps in this policy/procedure, it is likely that your clinical records will document a good faith effort to meet the resident's needs.

Chapter 400, FS and the federal OBRA law require you to meet the specialized needs of your residents in place. Those laws do identify rare occasions in which you may be able to discharge a person whose needs you are unable to meet. Chapter 400 does require you to meet the voluntary, involuntary, and transportation requirements of the Baker Act as a condition for licensure. It further permits a resident to be transferred or discharged only for medical reasons or for the welfare of other residents, and the right to be given reasonable advance notice of no less than 30 days of any involuntary transfer or discharge, except in the case of an emergency as determined by a licensed professional on the staff of the nursing home. The following provisions of chapter 400 may guide you:

> 400.0255 Resident transfer or discharge; requirements and procedures; hearings.--
> (1) As used in this section, the term:

(a) "Discharge" means to move a resident to a noninstitutional setting when the releasing facility ceases to be responsible for the resident's care.
(b) "Transfer" means to move a resident from the facility to another legally responsible institutional setting.
(2) Each facility licensed under this part must comply with subsection (9) and s. 400.022(1)(p) when deciding to discharge or transfer a resident.
(3) When a discharge or transfer is initiated by the nursing home, the nursing home administrator employed by the nursing home that is discharging or transferring the resident, or an individual employed by the nursing home who is designated by the nursing home administrator to act on behalf of the administration, must sign the notice of discharge or transfer. Any notice indicating a medical reason for transfer or discharge must either be signed by the resident's attending physician or the medical director of the facility, or include an attached written order for the discharge or transfer. The notice or the order must be signed by the resident's physician, medical director, treating physician, nurse practitioner, or physician assistant.
(7) At least 30 days prior to any proposed transfer or discharge, a facility must provide advance notice of the proposed transfer or discharge to the resident and, if known, to a family member or the resident's legal guardian or representative, except, in the following circumstances**, the facility shall give notice as soon as practicable before the transfer or discharge:**
(a) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility, and the circumstances are documented in the resident's medical records by the resident's physician; or
(b) The health or safety of other residents or facility employees would be endangered, and the circumstances are documented in the resident's medical records by the resident's physician or the medical director if the resident's physician is not available.
(8) The notice required by subsection (7) must be in writing and must contain all information required by state and federal law, rules, or regulations applicable to Medicaid or Medicare cases…
(10)(a) A resident is entitled to a fair hearing to challenge a facility's proposed transfer or discharge. The resident, or the resident's legal representative or designee, may request a hearing at any time within 90 days after the resident's receipt of the facility's notice of the proposed discharge or transfer.

Even if your facility is unable to accept the resident back, it would appear that you must among other things give the resident notice of his appeal rights. Further, at a minimum you should assist the resident to find an alternate nursing home that will accept him and meet his needs since the transfer to The Centers was for examination/short-term treatment, not as a discharge destination. My experience is that such residents are subsequently released by the Baker Act facility to a different nursing home that is licensed and staffed the same as the facility that made the discharge. This raises the issue for AHCA as to whether the first nursing facility should have been able to meet the resident's needs.

While there may be many appellate cases on this issue in Florida, I am only aware of one appellate case (Smith v. Chattanooga Medical Investors 2001) which stated that

> When the resident was ready to return from the hospital to the nursing facility, the nursing facility refused to admit him, claiming he was a dangerous patient. The

court stated that the facility could not refuse readmission to the resident on the grounds that he was dangerous. The court pointed out that federal law sets forth transfer/discharge procedures, including notice requirements, but that the nursing facility had followed none of those procedures.

You should consult with AHCA as it is the final arbiter.

Q. I am an attorney. We understand that a nursing home could not, after accepting someone, return them to DCF or refuse to continue to treat (or something to that effect). Is that still applicable?

This issue is very complicated as transfers from a nursing home to a Baker Act receiving facility aren't only governed by the Baker Act, but are also governed by Chapter 400, FS and the federal OBRA law.

Once a nursing home accepts a person, it can't transfer or discharge the resident without giving notice and right to appeal the decision. However, in specified exceptions, the transfer or discharge can occur in advance of the appeal hearing, as follows (I've included the full section from chapter 400 at the end of this message)

> **400.0255 Resident transfer or discharge; requirements and procedures; hearings.**
> (1)As used in this section, the term:
> (a)"Discharge" means to move a resident to a noninstitutional setting when the releasing facility ceases to be responsible for the resident's care.
> (b)"Transfer" means to move a resident from the facility to another legally responsible institutional setting.
> (3)When a discharge or transfer is initiated by the nursing home, the nursing home administrator…must sign the notice of discharge or transfer. Any notice indicating a medical reason for transfer or discharge must either be signed by the resident's attending physician or the medical director of the facility, or include an attached written order for the discharge or transfer. The notice or the order must be signed by the resident's physician, medical director, treating physician, nurse practitioner, or physician assistant.
> (5)A resident of any Medicaid or Medicare certified facility may challenge a decision by the facility to discharge or transfer the resident.
> (7)At least 30 days prior to any proposed transfer or discharge, a facility must provide advance notice of the proposed transfer or discharge to the resident and, if known, to a family member or the resident's legal guardian or representative, except, in the following circumstances, the facility shall give notice as soon as practicable before the transfer or discharge:
> (a)The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility, and the circumstances are documented in the resident's medical records by the resident's physician; or
> (b)The health or safety of other residents or facility employees would be endangered, and the circumstances are documented in the resident's medical records by the resident's physician or the medical director if the resident's physician is not available.

Even if one of the two exceptions identified above exist, the nursing home is still responsible for conducting discharge planning for the resident to an appropriate facility that can manage the resident's needs. A Baker Act receiving facility is not such a facility. A receiving facility is only intended to conduct psychiatric examinations and provide short-term psychiatric treatment – it can be appropriate in rare circumstances for a transfer, but it isn't an end placement. AHCA has cited nursing homes for failure to do discharge planning in such circumstances.

Before a person is sent to a receiving facility, the nursing home should have documented in the resident's care plan all of its efforts to stabilize the resident's care "in place" to avoid the dangers of such relocation trauma resulting from transfers.

There may be many court cases related to refusal to readmit residents from hospitals, but I have only one in my file. The Tennessee Court of Appeals ruled favorably for facility residents when a nursing home refused to readmit a resident who was ready to return from the hospital. The nursing home refused to admit him, claiming he was a "dangerous patient." The appellate court stated that the facility could not refuse readmission to the resident on the grounds that he was dangerous and also pointed out that federal law sets forth transfer/discharge procedures, including notice requirements, but that the nursing facility had followed none of those procedures.

AHCA recently prevailed in an appellate case against a nursing home for failing to comply with the Baker Act regarding voluntary, involuntary and transport provisions of the law.

Documentation

Q. I'm with AHCA. Is a nursing home required to have a copy of the Baker Act form in the resident's chart? My understanding was that there was no regulation requiring this if there was documentation in the record of everything that had been done, showing the need, contact with the physician, etc. A couple of other surveyors do not agree with this, and continue to want the form in the record at the nursing home. I do know that the medical record at the hospital needs to have a copy of the Baker Act form in it. Please advise

You are correct. The Baker Act law and rules clearly require a receiving facility to retain a copy of the initiation form and law enforcement transport form in the person's clinical record. However, the Baker Act law and rules are silent as to what must be in the sending facility's files.

However, it is surprising that a long-term care facility wouldn't retain such a copy of such an initiation document in the resident's file: The facility is the entity generating the voluntary or involuntary examination under the Baker Act. However, on rare occasions when the initiation is actually done by a law enforcement officer and that officer refused to leave a copy of the initiation or transport document with the facility, it is possible that no such documentation would be at the facility. The nursing home statute (chapter 429 has an equivalent provision for ALF's) includes the following provision:

400.102 Action by agency against licensee; grounds.--In addition to the grounds listed in part II of chapter 408, any of the following conditions shall be grounds for action by the agency against a licensee:
(3) Failure to follow the criteria and procedures provided under part I of chapter 394 relating to the transportation, voluntary admission, and involuntary examination of a nursing home resident

You may need to verify if any rules have been promulgated by AHCA or DOEA require the nursing home to retain a copy of these documents. It's good that you're looking for efforts made by the facility to avoid such methods as transfer under the Baker Act as such transfers can have very destructive results on a frail elder.

The Florida Health Care Association has developed a model policy to assist its members in dealing with residents who have behavioral issues. A good nursing home will have documented in its records the steps laid out in the FHCA document. The literature clearly identifies the risk of "transfer trauma" or "relocation trauma" for elder residents of long-term care facilities.