**Nursing Home Residents Rights Under Federal Law**

**National Academy of Elder Law Attorney’s**

**Advanced Elder Law Review Course**

**Edwin M. Boyer, Esq.**

**Boyer & Boyer, P.A.**

**46 North Washington Blvd. Suite 21**

**Sarasota, FL 34236**

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**941-365-2304**

**emboyer@boyerboyer.com**

The elderly generally end up in a long term care setting through a gradual progression of losses. When the elderly become decreasingly self sufficient, isolated, and vulnerable, and family and community can’t provide adequate services and support, the long term care system is often the only option.

The transition is often difficult for the resident and the family. Many of the problems confronting the elderly do not start with entry into the system, but must be dealt with there. New problems often arise because of the nature of the setting and how services are delivered there. Residents and families must make difficult adjustments to life in an institutional setting. Everyone working with the elderly in the long term care system must always appreciate the changes in lifestyle which occur including;

‑ set routines for meals and getting up and going to bed

‑ a decrease in contact with the community

‑ more free time due to structured activities available only certain times

‑ decreased privacy and independence

‑ fewer opportunities for decision making

‑ loss of home and many possessions and links to the past

‑ increased loneliness

‑ the need to adjust to staff and other residents

The regulatory scheme which has developed since the 1986 report of the Institute of Medicine entitled "Improving the quality of care in nursing homes" has established a high standard for long term care facilities which have increasingly shifted the focus to quality of care issues and residents rights. There are of course areas for improvement but as Iris C. Freeman, Executive Director of the Minnesota Alliance for Health Care Consumers said;

**"'What's past is prologue,' wrote Shakespeare. It is fitting that consumer advocates and others recall that only twenty-some years ago nursing home residents had little ground on which to refuse a plan of care without risking discharge. There was no right to convene a resident council or family council, and few homes had them. It was ordinary practice for medicaid-certified homes (often ones with religious auspices and lofty self-images) to charge large up-front fees and whatever else the traffic would bear, only to discharge the resident when the money was gone..... Mandatory abuse reporting was associated with child welfare alone. And an ombudsman was a esoteric public service concept associated with Scandinavian** **governments.**

**The point is to move the work forward. The rules themselves, regardless of how vital they may seem, are not the mission. The mission is to ensure that residents and families have systematic ways to make their needs and concerns known to nursing home staff and public officials whose decisions affect their lives. The mission is to ensure that nursing home residents can count on protection from maltreatment and on meaningful response when it occurs. The mission envisions nursing home residents as individuals with histories, preferences, and dignity in a systems that is benevolent to the poor." Iris C. Freeman, A Contemporary Advocacy Agenda for Nursing Home Consumers. Generations, P.52 (Winter 1995-1996).**

The key then for successful advocacy is knowledge of the laws and regulations and of the tools available for enforcement, as well as an understanding of the most common issues confronting residents and their families.

and to give practical tips on how to litigate a nursing home resident’s rights case by use of a case study.

**PART ONE**

**AN OVERVIEW OF FEDERAL LAW AND REGULATION**

It is important for advocates, families, and consumers to understand the standards, process and agencies involved in licensing and regulating long term care facilities. When a resident is confronted with an issue or problem, the minimum standards contained in state and federal law tell what kind of services care and physical surroundings to expect. If a facility fails to meet these standards, the standards serve as a guide as to how to comply with the laws and what remedies are available.

The Federal Government has had extensive laws and regulations for Nursing homes since the 1970's, because it finances resident care through Medicare/ Medicaid programs. The federal law specifically regulating nursing homes applies only to those facilities certified to accept Medicare/Medicaid payment for care.

**OBRA '87 - 42 U.S.C. 1395i‑3; 42 U.S.C. 1396r**

In 1987, Congress passed the Nursing Home Quality Reform Amendments of 1987 known as OBRA '87, because it was a part of the Omnibus Budget Reconciliation Act of 1987. OBRA '87 made major changes in the requirements for Medicare/Medicaid participating skilled Nursing Facilities (SNFs) and Nursing Facilities (NFS).

OBRA '87 and the regulatory initiatives of the 1980's and 1990's were largely a result of a study completed by the Institute of Medicine, an arm of the National Academy of Science. The report was called "Improving the Quality of Care in Nursing Homes." The purpose of the study was "to recommend changes in regulatory policies and procedures to enhance the ability of the regulatory system to assure that nursing home residents receive satisfactory care." The report generally concluded that market forces resulted in appalling quality of care and regulation of the industry was necessary. Many of the recommendations of the report were incorporated directly into OBRA '87 and subsequent regulations.

OBRA '87 was significant in that it shifted the regulatory focus to resident’s rights and quality of care. Residents rights were elevated to a higher level in the regulatory scheme and the focus of the law was attaining and maintaining the highest practical physical, mental, and psycho social well being instead of meeting minimum standards. 42 U.S.C. 1395i‑3 governs skilled nursing facilities (SNF's). 42 U.S.C. 1396r governs nursing facilities (NF's). The provisions are essentially the same. Both sections specify the requirements for, and assuring quality of care in nursing homes receiving Medicare/Medicaid funds. Subsection (a) of each section defines respectively skilled nursing facility and nursing facility. The remaining subsections deal with the following:

Subsection (b) - Requirements for Provisions of Services -42 U.S.C. 1395i-3(b); 42

U.S.C. 1396r(b).

Subsection c) - Residents Rights - 42 U.S.C. 1395i-3©; 42 U.S.C. 1396r©.

Subsection (d) - Administrative Requirements - 42 U.S.C. 1395i‑3(d); 42 U.S.C.

1396r(d).

Subsection (e) - State Requirements - 42 U.S.C. 1395i‑3(e); 42 U.S.C. 1396r(e)

Subsection (f) - Secretary's Requirements - 42 U.S.C. 1395i‑ 3(f); 42 U.S.C. 1396r(f).

Subsection (g) - Surveys and Qualification - 42 U.S.C. 1395i‑ 3(g); 42 U.S.C. 1396r(g).

Subsection (h) - Enforcement- 42 U.S.C. 1395i‑3(h), 42 U.S.C. 1396r(h)

**REQUIREMENTS FOR PROVISIONS OF SERVICES**

These subsections specifies the requirements for facilities relating to provision of services.

significantly it states that a facility "care for its residents in such a manner and in such an environment as will promote maintenance and enhancement of the quality of life of each resident" the services provided must "attain or maintain the highest practicable physical, mental, and psycho social well‑being of each resident in accordance with a written plan of care". The requirements of subsections (b) cover the following: (1) Quality of life (2) Resident Assessments (3) Nurses aid training (4) physician supervision and clinical records (5) Required social services (6) Nurse staffing . U.S.C.1395i-3(b) and 42 U.S.C.

1396r(b), requires a comprehensive, accurate, and standardized resident assessment within 14 days of admission, upon a significant change in condition, and at least every 12 months thereafter. The assessment is based upon uniform minimum data set (MDS) issued by the Secretary of the Department of Health & Human Services (hereafter, the Secretary), and is completed on a state selected Resident Assessment Instrument (RAI). The assessment describes the resident’s capability to perform daily life functions and significant impairments in functional capacity and must include identification of medical problems. The Resident Assessment Instrument contains Resident Assessment Protocols (RAP), which identify problems (triggers) and include suggestions for correction of the problems.

**RESIDENTS RIGHTS**

These subsections require facilities to promote and protect rights of each resident. The

law guarantees a comprehensive list of rights to each resident and requires the facilities to notify the resident of those rights. The rights include the following; (1) protection of resident funds

(2) free choice (3) privacy and confidentiality (4) grievances (5) examination of survey results

(6) work (7) mail (8) access and visitation rights (8) telephone (9) personal property (10) married couples (11) self administration of drugs (12) refusal of certain transfers.

**STATE REQUIREMENTS**

These subsections specify the requirements of the states relating to the facilities requirements. It outlines state requirements relative to: (1) nurses aide training (2) nurses aide registries (3) appeals process for discharge and transfer hearings (4) development of nursing administrator standards (5) specification of resident assessment instruments (6) pre-admission screening and resident review (7) notice of Medicaid rights (8) establishment alternate remedies to decertification.

**SURVEYS AND QUALIFICATION**

These subsections establish procedures for survey and certification. The appropriate state

certification agency makes an unannounced annual federal survey simultaneously with the state

licensing survey. They do the survey under contract with The Center for Medicare and Medicaid

Services (CMS).

The law authorized five forms of survey:

A standard survey is an unannounced survey conducted to determine quality of care

furnished as measured by a variety of indicators, a review of care plans, an audit of assessments to determine the adequacy of the plans of care, and a review of compliance with residents rights. Standard surveys are conducted no later than 15 months after the last survey with a statewide average interval of no more than 12 months.

.A special survey is a standard survey conducted within two months of change of ownership, administration or management, or director of nurses, to determine any decline in quality of care.

An extended survey is a survey conducted if a standard survey finds the facility

provided substandard quality of care, or otherwise at the discretion of the secretary. This survey is conducted immediately after the standard survey.

A validation survey is a survey conducted on a representative sample of facilities two months after the state survey to determine adequacy of the state survey.

A special compliance survey is a survey conducted where the secretary has reason to

question compliance.

Survey protocol is developed by the secretary. The federal survey protocol consists of

forms, procedures and interpretative guidelines. The protocol has been revised many times. Surveyors are presently operating under State Operations Manual Chapter 7 - Survey and Enforcement Process for Skilled Nursing. A copy can be found on the web sight for the United Stated Department of Health and Human Services.

Survey teams are trained interdisciplinary professionals free from conflicts of interest.

Results of the surveys are made available to the public.

**ENFORCEMENT**

These subsections establish an enforcement process. The congressional

goal was rapid enforcement and immediate correction of serious deficiencies. Enforcement regulations were proposed August 28, 1992 with final regulations adopted 11/10/94. These final enforcement rules are implemented by State operations manual Chapter 7 revised May 21, 2004. The regulations are found at 42 C.F.R. 488.406.

Deficiencies which immediately jeopardize the health or safety of the resident can result in appointment of a temporary manager, termination of providers participation or relocation of residents and closure.

Each facility that has a deficiency must submit a Plan of Correction (POC). Sanctions which may be imposed on a facility for non-compliance include: (1) directed in-service training (2) state monitoring (3) denial of payment for all Medicare or Medicaid admissions, or all new Medicare or Medicaid admissions (4) civil monetary penalties (5) Closure of the facility in emergency situations and/or transfer of residents (6) temporary management (7) termination

(8) Alternative state remedies approved by CMS.

**AMENDMENTS TO OBRA ‘87**

OBRA '87 reflected sweeping reform of national nursing home regulation. There was slow progress in meeting timetables and goals and issuing regulations resulting in several revisions to OBRA '87. These amendments were an attempt to fine tune the original legislation and to mandate effectiveness of portions of the legislation. The Medicare Catastrophic Coverage Act of 1988, amended parts of OBRA '87 relative to nurses aide training (extending requirements to January 1, 1990); nurses aide registry requirements (making the information available to the public), and abuse neglect and exploitation investigation (requiring states to make findings and notify other licensing agencies relative to nurses aides). The act also required HCFA (now CMS ) to issue regulations to carry out these provisions.

OBRA '89 again delayed implementation of the nurses aide training requirements until October 1990, and required nurses aide training in the care of cognitively impaired residents, and in recognition of mental health and social service needs.

OBRA '90 included changes to strengthen nurses aide training and competency, and requirements allowing residents to have access to their current clinical records on request within 24 hours. Also facilities were required to make statement of deficiencies available to the public. More importantly, OBRA '90 interpreted OBRA '87 provisions requiring facilities to perform PASARR (preadmission screening and annual resident review) to insure that persons suffering from mental illness or mental retardation are not admitted but receive other appropriate placement. OBRA'90 made an exception for people who had lived in a facility for 30 months to prevent their discharge. OBRA '90 also clarified that someone with a secondary diagnosis of dementia and a primary diagnosis other than a serious mental illness should not be screened out.

**REGULATIONS UNDER OBRA '87**

HCFA published final regulations under OBRA '87, on February 2nd 1989 setting forth the conditions for participation of facilities under the Medicare/Medicaid program. As with OBRA '87, the focus was on resident’s quality of care rather than minimum standard compliance. The regulations promulgated under the act are found at 42 C.F.R. 431 et seq. The regulations are organized as follows:

(a) Residents Rights 42 C.F.R. §483.10

(b) Admission, transfer and discharge rights 42 C.F.R. §483.12

© Resident behavior and facility practices 42 C.F.R. §483.13

(d) Quality of Life 42 C.F.R. §483.15

(e) Resident Assessment 42 C.F.R. §483.20

(f) Quality of Care 42 C.F.R. §483.25

(g) Nursing Services 42 C.F.R. §483.30

(h) Dietary services 42 C.F.R. §483.35

(I) Physician services 42 C.F.R. §483.40

(j) Specialized rehabilitative services 42 C.F.R. §483.45

(k) Dental Services 42 C.F.R. §483.55

(l) Pharmacy Services 42 C.F.R. §483.60

(m) Infection control 42 C.F.R. §483.65

(n) Physical Environment 42 C.F.R. §483.70

**CHANGES IN THE REGULATIONS**

The Regulations were modified by changes published September 26, 1991. These changes modified how the conditions of participation were categorized. Under the 1989 Regulations there were level A requirements (conditions ‑ a broad group of standards dealing with an area of service within a facility) and level B requirements (standards ‑ specific standards within a broader level A group requirement). reference to level A and Level B were eliminated on the basis that congress intended that the regulatory system assure that all facilities comply with all standards.

February 6, 1992 changes in the regulations dealt with, care requirements for use of restraints, §483.13 (2); qualification for administrators, §483.35 (3); notice of Medicaid rights, §483.10(B)(5), and notice of transfer and discharge, §483.12.

On November 30, 1992 final regulations were published for pre-admission screening and annual resident review process (PASARR) which included screening for mental health patients who are residents of nursing homes. December 28, 1992 changes established requirements concerning the use of resident assessment instruments (§483.20(b).

Although these regulations have been revised and added to since 1989, they have not been comprehensively reviewed and revised since 1991 (56 Fed. Reg. 48,826, September 26, 1991). Since then, there have been significant changes in the long-term care population, resident care practices, and long-term care facilities practices. Also, there has been extensive research on best practices for residents’ care.

             Over the last few years, the Centers for Medicare and Medicaid Services, of the Department of Health and Human Services, has been undergoing a comprehensive evaluation of the regulations and has made significant changes. Phase 1 of the new regulations became effective on November 28, 2016. Phase 2 will become effective on November 28, 2017. Phase 3 will become effective on November 28, 2019. A summary of the regulatory changes can be found at https://federalregister.gov/d/2016-23503.

**PART TWO**

**COMMON ISSUES CONFRONTING LONG TERM CARE**

**RESIDENTS**

Advocates for residents of long term facilities frequently see recurring violations of law and regulations affecting those residents. Many times, families and residents do nothing either because they lack knowledge of what their rights and the facilities responsibilities are, or they are afraid to protest out of a feeling of helplessness or fear of retribution. some, particularly at time of admission are in a vulnerable position and they find it easier to simply give in or find another facility.

The most frequent and recurring problems involve the following:

1. improper admission practices

2. improper discharge and transfer practices

3. violation of resident’s rights

4. improper or inadequate care

5. refusal to honor medical decisions

As an example, in Florida, of the 8667 complaints filed with the Florida Long Term Ombudsman councils in 2002 and 2003, 48% were called in by a friend or family member. 19% were from residents themselves. The most frequent common complaints ranked from the highest to the lowest were:

1. Improper administration of medication

2. Accidents falls and improper handling

3. Personal hygiene

4. Unattended symptoms

5. Improper discharge

6. Quantity and quality of the menu

7. Shortage of staff

8. Dignity and respect issues

9. Failure to respond to call lights

10. Staff attitudes

Since 1986, the number of complaints has steadily increased from year to year, except

1991, when there was a sharp decline. This coincided with OBRA 90 which greatly strengthened

requirements for resident’s care.

An advocate, resident or family member with knowledge of the law and regulations, can accomplish a great deal in improving the quality of life of residents and in preventing inappropriate practices. Frequently facility staff do not have a complete understanding of their responsibilities and obligations to residents when it come to issues of residents rights, transfer and discharge and the like. An educated resident, family member or advocate can provide a great service in education of staff as to their obligations. Following are some of the most common problems confronting nursing home residents and their families.

**FINANCIAL SCREENING**

Some facilities may attempt to require substantiation of assets and ability to pay prior to admission in order to assure that the resident will remain private pay. Although some practices are permissible there is a point at which the "financial screening" becomes improper. If a facility asks for personal financial information for the purpose of showing that the resident is not eligible for Medicaid benefits and won't apply in the near future, it is impermissible. The facility may inquire if the applicant is eligible for Medicaid or has private insurance. Following are specific prohibitions against forms of financial screening.

**WAIVING MEDICAID AS A CONDITION TO ADMISSION**

Some facilities may require the resident or family to waive the residents right to apply for

Medicaid assistance. They either require a private pay contract or obtain an agreement that the resident will not apply for assistance for a minimum number of months to insure private pay for at least a limited period.

**The Law - 42 C.F.R. 483.12(d)(1)(I)**

**"(d) Admissions Policy.**

**(1) The facility must-**

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

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

A variation of the above is the practice of admitting a resident who makes application for Medicaid assistance during the month of admission. The facility will require private pay where the resident is "Medicaid pending". If Medicaid assistance is approved two or three months later retroactive to the month of application, they will refund the money. This practice is also a violation of Federal Law. State Operations Manual - Appendix PP - Guidance to Surveyors for Long Term Care Facilities issued by The Centers for Medicare and Medicaid Services (Rev. 55, 12-02-09) in instructions to surveyors states “a resident cannot be transferred for non-payment if he or she has submitted to a third party payor all paperwork necessary for the bill to be paid. Non-payment would occur if a third party payor, including Medicare or Medicaid, denies the claim and the resident refused to pay for his or her stay.”

**THIRD PARTY GUARANTEES AND SOLICITATION OF SUPPLEMENTATION AS CONDITION TO ADMISSION**

Facilities may require family members to guarantee payment if the resident is Medicaid eligible on admission or subsequently becomes Medicaid eligible.

**The Law - 42 C.F.R. 483.12(d)(2)(3)**

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

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

Consider this example: Your client, whose mother is in Wisteria nursing home, signs a contract when his mother is admitted to a local nursing home. She was on Medicare then Medicaid. Her income covers $900.00 of the monthly bill. The contract says "I understand that I am not assuming personal liability for any payment except up to the amount of the income or resources belonging to the resident over which I had, have or will have authorized control."

Well, mom got better and went home. And son got a letter from the care provider for the "past due" amount of $540. The letter says "Per the executed agreement, Wisteria Nursing Home looks to you as personally liable for the above outstanding balance." It is clear that they want him to reach into his own pocket to pay this bill. Facilities are becoming increasingly creative in drafting contracts to evade federal law.

**MEDICAID BED AVAILABLE**

Facilities may attempt to make less than all beds available for Medicaid residents. Medicaid eligible residents may be told upon admission to a Medicaid certified facility that there are no Medicaid beds available. The number or percentage of Medicaid occupied beds is established in the facility's Certificate of Need (C.O.N.). If the number of Medicaid occupied beds meets or exceed that number or percentage the facility may deny admission. A facility however may exceed their C.O.N. and admit additional Medicaid residents and they will receive payment from Medicaid. Although there is no specific regulatory requirement that says a facility must accept a Medicaid eligible resident for admission, if a facility is under their C.O.N. number, their denial of admission to a Medicaid eligible resident could be challenged as a type of financial screening prohibited under 43 C.F.R. §483.12(d), or by insisting that the facility increase it’s Medicaid certified beds which is very easy to do. For an excellent discussion of this issue see Long Term Care Advocacy by Erik M. Carlson, §304.1, Lexis-Nexis (2006)

On the other hand, if a facility has all certified Medicaid beds occupied and an existing resident becomes Medicaid eligible, that resident may not be discharged. Under 42 C.F.R. § 483.12(a)(2), non payment is a valid reason for discharge. However, 42 C.F.R. § 483.12(a)(2) states that a resident can be discharged if “the resident fails to pay (or to have paid under Medicare or Medicaid) for a stay at the facility”. The interpretative guidelines under this section state, “A resident cannot be transferred for non-payment if he or she has submitted to a third party payor, all the paperwork necessary for the bill to be paid.” The interpretative guidelines under 42 C.F.R. 483(a)(2) and (3) also state “Conversion from private pay rate to payment at the Medicaid rate does not constitute non-payment”.

Also, consider the facts surrounding the discharge of Anna which occurred in 2010.Anna was a resident of The Inn at Saltair. The Inn is a 60 bed licensed facility with 47 of its 60 beds certified for Medicare residents, and 13 beds dually certified for Medicare and Medicaid. Anna was admitted to the Inn in November 2009. Anna was Medicare qualified upon admission, but was not Medicaid qualified.. Anna was placed in a bed certified for Medicare only and not for

Medicaid. At the time of Annas admission to the Inn, the Inn’s 13 dually certified Medicare/Medicaid beds were all occupied. Some of the beds at that time and through May

2010, were occupied by private pay residents in “spend-down” status, spending down their assets

to become Medicaid-eligible. The Inn has a detailed notice provision in the admissions contract advising the residents that the Inn has taken the option offered by Federal and State law to certify only a limited number of beds for Medicaid program participation, and that a Medicaid bed may not be available when residents become Medicaid eligible.

As Anna approached the end of her 100 days of Medicare coverage, in early February

2010, The Inn was notified that Anna would be submitting an application for Medicaid ICP

coverage. The Inn advised Anna and her daughter that there were no Medicaid certified beds

available, but that Anna’s name would be placed on a waiting list for a Medicaid-certified bed.

When anna’s Medicare coverage ended, the Inn began charging Anna’s daughter as a private par resident, and sent her bills which the daughter did not pay. Anna’s daughter tendered checks intended for the resident responsibility portion assuming Medicaid ICP coverage.

On April 1, 2010, The Inn delivered its 30 day notice of discharge, on the grounds of non-payment after reasonable and appropriate notice. On April 6, 2010, Anna appealed.

Anna asserts that the discharge is improper for the following reasons:

1. The discharge was improper because it was a discharge based upon a change in method of payment in violation of **42 C.F.R. 483.12(a)**, and Anna arranged to have her stay paid by Medicaid as contemplated by **42 C.F.R. 483.12(a)**. The interpretive guidelines for **42 C.F.R. 483.12(a)** state that conversion from a private pay rate to payment at the Medicaid rate does not constitute non-payment. Further, the guidelines state that a resident cannot be transferred for non-payment if he or she has submitted to a third party all the paperwork necessary for the bill to be paid. Non-payment would occur if Medicaid denied the claim.

2. The Inn discriminates based upon payment source in violation of **42 C.F.R. 483.12(c)(1)**. The private pay “spend down” residents are given preference and treated differently from Medicaid residents who are discharged if no certified Medicaid bed is available.

3. The bed occupancy policies which permit private pay “spend-down” residents to occupy Medicaid certified beds until they become Medicaid eligible during their stay at the Inn when the “spend-down” beds are full, combined with the Notice of Limited Medicaid Bed Certification in the admission contract constitutes discrimination based upon payment source in violation of **42 C.F.R. 483.12(c)(1),** and financial screening, indirect duration of stay contract, and an indirect waiver of Medicaid rights in violation of **42 C.F.R. 483.12(d)(2).**

4. The Inn could have, but failed to seek re-certification of beds to increase the number of certified Medicaid beds to accommodate the needs of Anna.

The Inn responds to Anna’s assertions of improper discharge as follows:

1. Under federal and state law, nursing facilities like the Inn are permitted to limit their participation in the Medicaid or Medicare programs by having a limited number of beds certified for participation in each program. Further, The Inn has a detailed notice provision in its admission contract notifying residents of its limited participation in the Medicaid program and what that may mean for residents who may need a Medicaid certified bed if one is not available. This is not financial screening.

2. The Inn’s position is that Medicaid is not a payor source for residents who are not in the Medicaid certified part of the Inn. This is fully supported by regulations, interpretive guidelines, State Operations manual and interpretations of AHCA.

3. The discharge is not based on change in payment method. It is based on the fact that medicaid is not an available payment method or an available payor source for Anna’s bed, and there is no Medicaid-certified bd available to transfer to in order for the Inn to be allowed to bill Medicaid for Anna’s stay.

4. Anna cites the transfer and discharge rule language: “for a resident who becomes eligible for Medicaid after admission to a nursing facility, the nursing facility may charge a resident only allowable charges under Medicaid. But Anna was never admitted to the Inn’s “nursing facility” because there was no Medicaid bed available in the “nursing facility.” “Nursing facility” is defined in **42 C.F.R. 483.5** to mean the part of a nursing home that meets Medicaid requirements, while the separate term “skilled nursing facility” is the part that meets Medicare requirements. The regulations and interpretive guidelines, along with the State Operations manual, also define “distinct part” - which is descriptive of when an institution chooses to have a limited number of its beds certified for participation in either the Medicare or Medicaid program. And **42 C.F.R. 483.5(a)** states “For Medicare and Medicaid purposes (including eligibility, coverage, certification, and payment), the “facility” is always the entity that participates in the program, whether that entity is comprised of all of, or a distinct part of a larger institution.” Further, the Inn cites 56 Federal Register 48826, 48839 (Notice of Final Rule, September 26, 1991 (adopting the Transfer and Discharge Rule and amending other rules of **42 C.F.R. 483)** in which HCFA stated, “Briefly, both Medicare and Medicaid permit a SNF (Skilled Nursing Facility) or NF (Nursing Facility) to be a “distinct part” of an institution...Medicaid payment can only be made to a NF (or a distinct part of an institution that is participating as a NF)...

6. The Inn has no obligation to seek re-certification of its Medicaid beds.

If you were the hearing officer how would you rule? Was the discharge proper or a

violation of Federal Law?

**BED HOLD POLICIES**

Some facilities may refuse readmission to Medicaid residents who require hospital admission and then subsequent return to the facility. It could be argued that the failure of the facility to strictly comply with the Federal and State Regulations regarding the bed hold policy would constitute an improper discharge.

**The law - 42 C.F.R. 483.12(b)**

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

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

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

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

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

**(I) Requires the services provided by the facility; and**

**(ii) is eligible for Medicaid nursing family services.**

**The Law - 42 C.F.R. 483.12© - Equal access to quality care.**

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

**(c)(2) The facility may charge any amount for services furnished to non-Medicaid**

**residents consistent with the notice requirement in §483.10(b)(5)(I) and (b)(6) describing the charges; and**

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

**IMPROPER TRANSFER AND DISCHARGE**

Improper transfer and discharge practices can take many forms but generally involve attempts by the facility to transfer or discharge a resident because they are simply too difficult to care for, have a family that the facility feels is difficult to deal with, or the resident's method of payment changes from private pay to Medicaid. Consider the following example:

**Lea is a 101 year old Medicaid resident of a nursing home. She speaks very little English, loves a great deal of attention, and only wants to return to Italy. She can walk with assistance but requires help with bathing and dressing. She also has compression fractures in the lumbar region. Lea has complained to her son on three occasions of rough treatment by aides when lifting her with pain in her back. He repeatedly complains to the administration about his mother's treatment. In one instance he files an abuse report against the facility which turns out to be unfounded. He is very insistent with the facility and they consider him a troublemaker. He hires an attorney and threatens to sue the facility for battery. Finally the facility sends a letter to the son and Lea which states as follows:**

**"While we believe the facility has provided good care to your mother, obviously you do not think so. If you believe your accusations, I would think you would want to remove her from our facility as soon as possible. Regardless whether you do, it's clear to us that there's nothing we can do to satisfy you, and that it's best for all concerned that your mother be moved as soon as possible. This letter serves as notice of discharge of your mother from the facility as of April 10, 1997. Our reason for the discharge is that a transfer is necessary for your mother's welfare, since she apparently fees (albeit with no justification that we know of) threatened here. In view of her apparent state of mind, and yours, it is our conclusion that her needs cannot be met in the facility."**

**The Law - 42 U.S.C. 1395i-3(c)(2); 42 U.S.C. 1395r(c)(2);**

**42 U.S.C. 1396r(c)(1)(a)(o);**

**42 C.F.R. 483,12; 42 C.F.R. 488.15(e)**

**42 C.F.R. 483.12(a) (1) Transfer and Discharge**

**(1) Definition**

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

**42 C.F.R. 483.12(a)(2) Transfer and Discharge Requirements**

**The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless:**

**(I) the transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility;**

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

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

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

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

**(vi) the facility ceases to operate.**

**42 C.F.R. 483.12(a)(3) Documentation**

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

**(I) The resident’s physician when transfer or discharge is necessary under paragraph (a)(2)(I) or paragraph (a)(2)ii); and**

**(ii) A physician when transfer or discharge is necessary under paragraph (a)(2)(iv)**

**42 C.F.R.483.12(a)(4) -Notice Before Transfer**

**Before a facility transfers or discharges a resident, the facility must;**

**(I) The facility must 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.**

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

**42 C.F.R. 48312(a)(5) Timing of the notice**

**(I) Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer and 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 the 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**

**© 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.**

**42 C.F.R. 483.12(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 the transfer or discharge**

**(ii) The effective date of the 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.**

**42 C.F.R. 483.12(a)(7) Orientation for Transfer and Discharge**

**A facility must provide sufficient preparation and orientation to residents to insure safe and orderly transfer or discharge from the facility.**

**42 C.F.R. 483.15(e)(2) - a resident has a right to receive notice before the resident’s room or roommate in the facility is changed.**

Any transfer or discharge should be closely examined to determine if the facility made efforts to reasonably accommodate the resident's needs and preferences before transfer (42C.F.R. 438.15(e)). According to interpretative guidelines issued by the Secretary, reasonable accommodation means those adaptations of the facilities physical environment and staff behavior to assist residents in maintaining independent functioning, dignity, well being and self determination.

**IMPROPER AND INADEQUATE CARE**

29.64% of the complaints received by the Long Term Care Ombudsman councils in Florida in 2001 were complaints of inadequate care. Inadequate care often takes the form of neglect or abuse. As Scott R. Severns said in his presentation at the Stetson College of Law Eight Seminar on Elder Law, March 15, 199;

**"Most negligence occurs not because of some intentional design, but because of a more insidious combination of forces such as time, money and emotional energies. Too often in a nursing home setting there is always an excuse for the neglect of an elderly resident. Therefore the advocate for the elderly must be that much more knowledgeable, that much more observant, and that much more vigilant." (Scott R. Severns, Bringing the Power of the Consumer to Improving Quality of Life for Nursing Home Residents, Stetson University College of Law Eighth Seminar on Elder Law - The Changing Face of Elder Law (March 15, 1996.)**

**The Law - U.S.C. 1395i-3(b)(1)(a); 42 U.S.C. , 1395r(b)(1)(a)**

**(1) Quality of life**

**(a) in general A skilled nursing facility must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident.**

**The Law - 42 U.S.C. 1395i-3(b)(1)(B)2; 42 U.S.C.; 1396r(B)(1)(b)(2)**

**(2) Scope of services and activities under plan of care**

**A skilled nursing facility must provide services to attain or maintain the highest practicable physical, mental, and psycho social well-being of each resident, in accordance with a written plan of care which –**

**(A) describes the medical, nursing, and psycho social needs of the resident and how such needs will be met;**

**(B) is initially prepared, with the participation to the extent practicable of the resident or the resident's family or legal representative, by a team which includes the resident's attending physician and a registered professional nurse with responsibility for the resident; and**

**© is periodically reviewed and revised by such team after each assessment under paragraph (3).**

**The Law - 42 C.F.R. 493.15**

**A facility must care for its residents in an environment that promotes maintenance or enhancement of each resident's quality of life.**

**The Law - 42 C.F.R. 483.25**

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

**FAILURE TO FOLLOW MEDICAL DECISIONS OF RESIDENTS, PROXIES OR SURROGATES**

Frequently facilities refuse to honor medical decisions of residents or their surrogates or attempt to discharge the resident who refuses medical treatment. Consider the following example: Mrs. Jones is the health care surrogate for her husband who was transferred from the hospital to a nursing home. Although no guardian has been appointed Mr. Jones is incompetent to give informed medical consent and this has been appropriately documented in his record. Mr. Jones' health care surrogate appointment also contains a living will which expresses his desire that life support not be used, including nutrition and hydration, if he is in a terminal conditions with no reasonable probability of recovery. Mr. Jones has terminal cancer, and his wife as his surrogate has instructed the facility not to use nutrition or hydration. One morning Mr. Jones says to the nurse, "I'm thirsty." The facility insists on administering nutrition and hydration claiming that he has revoked his living will. The wife is forced to seek legal counsel to resolve the situation. Eventually the facility relents and the tube is withdrawn.

**The Law - 42 2 C.F.R.483.10(b)(4)**

**(b) The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section; and**

**REMEDIES AND RESOURCES**

Advocates, residents and families should be aware of the legal remedies available for violation of law and regulation as well as other resources for advocacy. Below is a summary of these remedies and resources.

**Statutory Remedies Under Federal Law**

OBRA '87 does not create a private cause of action against a facility for violation of the law or regulation. In some States OBRA '87 can be used as a basis for a negligence action against a facility because it establishes a standard of care which a facility has a duty to meet.

**Statutory Remedies Under State Law**

Many states have some version of a civil enforcement provision for violation of residents rights in nursing homes and assisted living facilities, which may include a provision for recovery of attorneys fees allowing residents access to the courts. As an example, in Florida, a prevailing resident in an action involving injunctive relief or administrative hearings (such as a discharge case) can recover up to $25,000 in attorney’s fees.

**Common Law Remedies**

There are a variety of common law remedies available to residents as well as remedies using statutes not specifically governing nursing homes and assisted living facilities. Depending upon the circumstances these could include actions for negligence, breach of contract, breach of fiduciary duty, actions for fraud, deceptive trade practices, and actions governing abuse and exploitation.

**Complaints Filed with Government Agencies**

OBRA '87, state statutes, and the appropriate regulations provide for a mandatory complaint investigation process. For instance, in Florida, complaints against facilities who fail to comply with any provisions of the statutes or regulations can be filed with the following agencies:

1. CMS

2. Agency for Health Care Administration

3. Florida Department of Health and Rehabilitative Services office of Aging and Adult Services (adult Family Care Homes)

4. Department of Professional Regulation (complaints against administrators, nurses, physicians, and other professionals in the long term care setting.

5. Long Term Care Ombudsman Councils investigate complaints by residents in nursing homes, assisted living facilities and adult family care homes

6. Local Health, fire, and code enforcement agencies

7. Abuse Hot Line

8. Attorney General, Medicaid Fraud Control Unit

**Advocacy Groups and other resources**

A variety of advocacy groups can provide very useful information, and assistance to advocates, families, and residents. Some of these are listed below:

1. National Senior Citizens Law Center

1101, 14th Street NW Suite 400

Washington, DC 20005

Tel. (202) 289-6976

www.nsclc.org

2. National Citizens Coalition for Nursing

Home Reform

1828 L Street, NW, Suite 801

Washington, DC 20036

Tel. (202)332-2276

www.nccnhr.org

3. National Academy of Elder Law Attorneys, Inc.

1604 North Country Club Road

Tucson, Arizona 85716-3102

4. Carlson, Erik. Long Term Care Advocacy, Lexis-Nexis (2006)

5. Carlson, Erik M. And Bau Hsiao, Katherine, Baby Boomer’s Guide to Nursing Home Care, National Senior Citizens Law Center, Taylor Trade Publishing (2006)