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Resident Rights

REGULATORY FOCUS BULLETIN :
Federal Law

FILE TOPIC: Resident Rights

If a resident is confused and disoriented to the point of not being able to understand what is being communicated to them and the resident has not been adjudicated incompetent although the physician has deemed the resident incompetent, must the resident sign the admission documents or is it sufficient that the responsible party sign?

Each resident who understands the admission paperwork needs to sign the admission documents. If a resident is clearly unable to understand what is being communicated, even if he/she has not been adjudicated incompetent, the facility needs to document this in the medical record, and the responsible party may sign the documents.

When a resident's competence is questionable, as determined by the facility's assessment, it is acceptable for the facility to request signatures from both the resident and the responsible party.

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FILE TOPIC: Resident Rights

There is apparent conflict between Resident Rights, 42 CFR §483.10(b)(4), to refuse treatment and frequency of required physician visits, 42 CFR §483.40(c)(1). Since the advent of the Medicare Program in 1966, there has always been the question of requiring physician visits to privately paying residents at fixed intervals. Now, with the aforementioned paradox in mind, the question can be asked if program residents and/or private residents can refuse physician visits at the specified intervals.

There is not a conflict. Regulation 42 CFR §483.10 (b)(4) provides that the long term care facility resident has the right to refuse physician visits that would otherwise be made in accordance with the prescribed schedule in 42 CFR §483.40 (c)(1). It is important to note that 10A NCAC 13D .2501 (b) requires the same physician visitation intervals as the federal requirement. It is expected that a facility should be able to provide evidence of the resident's refusal of such treatment in a manner that would substantiate that the refusal is, in fact, made at the resident's own initiative. Whenever a resident refuses treatment, it is also expected that the facility will assess the reasons for the resident's refusal, clarify the reasons for refusal and educate the resident as to the consequences of refusal, offer alternative treatments, and continue to provide all other services.

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FILE TOPIC: Resident Rights

Is there a minimum time frame for supervised smoking to assure resident's rights are maintained?

No. Facilities should communicate to residents before admission and through ongoing policies what facility policies are related to smoking. The facility should work with residents who are smokers individually to develop a program that meets the needs of both the resident and the facility.

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FILE TOPIC: Resident Rights

Can the facility use a "bell" for a resident to ring who cannot push the call bell button due to finger contracture or deformity?

A "bell" is one device that can be used in this situation if the resident has the dexterity to use it and it can be heard "on the hall" by the direct care staff

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FILE TOPIC: Resident Rights

Does the water pitcher and cup need to be accessible to residents who cannot pour their own water?

No. Water needs to be accessible for staff to provide fluids. This does not necessarily mean immediately beside the resident's bed

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FILE TOPIC: Resident Rights

Do cordless telephones meet the requirements of 42 CFR §483.10(k) which states: "The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard?"

The use of cordless telephones is permissible. Privacy should be afforded to all residents when making or receiving calls unless the resident chooses otherwise.

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FILE TOPIC: Resident Rights

Can a facility be cited for not holding a bed for a Medicaid resident?

A facility is not required to hold a bed for a resident who has been discharged to the hospital unless payment is made by the resident or by someone on his behalf (privately) to retain the bed. However, a resident may have a right to return to the first available bed at the resident's level of care under state or federal law.

Briefly stated, the applicable law and rules are as follows:

(1) Under NC state law 131E -130, all residents, regardless of payor source or level of care, have the right to the first available bed at their level of care if two things occur within 15 days: (a) the resident is ready to be discharged back to the nursing facility within 15 days from the date the resident was admitted to the hospital; and, (b) the facility receives written notification from the hospital of the specific date of discharge (notice must be within the 15 day period). Under this law, returning residents have priority over new admissions to the facility. This law does not apply if the facility cannot provide the resident with the level of care he or she needs (example: the resident has specialized care needs which exceed the level of care offered by the facility).

(2) Under federal OBRA regulations, all Medicaid-eligible residents are entitled to the first available bed in a semi-private room at their appropriate level of care if the resident still needs care of the type offered by the facility. Under the federal rule for Medicaid-eligible residents, there is no time limit or cut-off point regarding this right as there is under state law.

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FILE TOPIC: Resident Rights

Will a facility be cited if a resident chooses to be dressed in pajamas rather than street clothes?

No. Residents should be allowed the freedom to dress as they choose.

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FILE TOPIC: Resident Rights

Please clarify Tag F156 section (iii)

...a posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit.

See approved Regulatory Focus Bulletin listing to be posted in nursing facilities, 42 CFR §483.10(b)(7):

STATE CLIENT ADVOCACY GROUPS

Division of Health Service Regulation – Nursing Home Licensure and Certification Section
2711 Mail Service Center
Raleigh, NC 27699-2711
(919)855-4520

Division of Health Service Regulation - Complaint Intake Unit
2711 Mail Service Center
Raleigh, NC 27699-2711
(919)855-4500 or 1-800-624-3004

Disability Rights North Carolina
2626 Glenwood Avenue
Raleigh, NC 27608
1-877-235-4210 / 1-919-856-2195
www.cladisabilitylaw.orgm

NC Department of Human & Human Services Care Line 1-800-662-7030

Local County Department of Social Services

Medicaid Fraud Unit (Program Integrity)
Division of Medical Assistance
2515 Mail Service Center
Raleigh, NC 27699-2515
(919)647-8000

North Carolina State Ombudsman
Division of Aging and Adult Services
2101 Mail Service Center
Raleigh, NC 27699-2101
(919)733-3983

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FILE TOPIC: Resident Rights

Does a resident's right to privacy during medical treatments also extend to glucometer and blood sugar checks such that performing these procedures at the nurses' station would be inappropriate?

Yes, privacy should be extended during treatments unless the resident chooses otherwise. For example, if the resident comes to the desk asking to have the blood sugar check done, this is permissible as long as other residents who may witness the procedure are not offended.

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FILE TOPIC: Resident Rights

Is it permissible for a nurse (RN or LPN) to put a resident's medication in their food if the resident is combative, confused, and will not take medication orally? If acceptable, is a physician's order needed?

Medications may be mixed with liquids and/or food if the resident refuses to take the medication orally. The nurse needs to be aware of possible food/drug interactions or a listing/resource should be consulted before mixing medications with food. A physician's order to mix with liquid or food is not necessary. The resident's responsible party should be made aware of the facility's intervention.

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FILE TOPIC: Resident Rights

Will a facility be cited for a violation of resident's rights when a resident or several residents are bathed after lunch?

No. This would not be an automatic citation. Residents are allowed to state a preference for bath time, e.g., many residents may prefer an evening bath. The resident's right to appropriate care would include face and hands washed before and after meals, incontinent care, mouth care and hair combed. These aspects of personal care should be provided even if the bath is not completed until the afternoon or evening.

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FILE TOPIC: Resident Rights

Can resident names be used in taped exit conferences?

No. Resident names cannot be used in an exit conference whether it is taped or not.

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FILE TOPIC: Resident Rights

Is it a violation of resident's rights not to receive mail on Saturday?

The facility is required to provide mail to residents each day that the post office delivers mail, including Saturdays. Interpretive Guidance for §483.10(i)(1)-(2) indicates, "Promptly" means delivery of mail or other materials to the resident within 24 hours of delivery by the postal service (including a post office box) and delivery of outgoing mail to the postal service within 24 hours, except when there is no regularly scheduled postal delivery and pick-up service".

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FILE TOPIC: Resident Rights

Can surveyors give the names of the residents that were cited as part of a deficiency?

Resident names are to be shared during the survey with the nursing facility staff who have been designated at the entrance conference by the administrator as long as there is not breech of confidence. For example, names of residents who need grooming (nail care, bathing, etc.), residents not turned, repositioned, or released from restraints in a timely manner, acute episodes not followed up, decubiti not assessed or weight loss.

Surveyor interviews of residents are confidential. When a resident requests anonymity, their names are not to be disclosed. A resident's name would not be used, for example, when the resident complained of cold food, staff shortages or call bells not answered.

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FILE TOPIC: Resident Rights

Is it a Resident's Rights violation for "No Code" residents to wear color-coded identification bracelets?

No.

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FILE TOPIC: Resident Rights

Is it a violation of residents' rights for residents to be viewed by nonresidents (visitors, family members of other residents, etc.) during mealtime, especially if they must be fed or assisted? This refers to residents whose eating may be difficult or "messy" or who may drool, cough, have problems chewing or swallowing.

No. Grouping of residents with similar abilities may be appropriate during mealtimes. Visitors and family members often visit during this time. It would constitute a violation of residents' rights, however, if the resident preferred privacy during this time. In that case, other provisions should be made to assure residents' privacy.

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FILE TOPIC: Resident Rights

If a resident is confused or combative and refuses to take medications, what should the facility do?

The facility is responsible for evaluating the needs of the resident and the resident's concurrent rights to both receive needed treatment and to refuse treatment. A confused or combative resident may have either right violated in the event assessment and evaluation of the individual situation are not carried out. Refusal of treatment by the confused and combative resident must be consistently documented in the medical record. A plan of care must be developed. Involvement of the resident, family, physician, and resident care planning team may assist in the identification of treatment alternatives.

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FILE TOPIC: Resident Rights

Is it permissible to place body diagrams at the head of beds for residents on drainage/secretion precautions and circle or highlight the area of the body that is draining?

No.

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FILE TOPIC: Resident Rights

Is it a violation of resident's rights to administer eye drops or medications in the dining room if the resident does not object?

No, it is not a violation of resident's rights.

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FILE TOPIC: Resident Rights

Is it permissible for facility staff to awaken residents for routine bathing during the night shift? This would not include those residents who themselves have chosen this as their preferred time, nor those residents who are unable to sleep and staff have determined that this might promote sleep.

No.

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FILE TOPIC: Resident Rights

The N.C. Patient Bill of Rights, Article 30, Right #3, states: "At the time of admission and during his stay a resident is to receive a written statement of services and related charges. A written receipt must be retained by the facility in a resident's file.

Following admission, where services/charges change, how does the facility comply with the requirement of retaining a written receipt?

A "written receipt" would constitute a statement the resident or responsible party signs that he/she has received the written information. How the facility chooses to do this is at its discretion. It is also appropriate that when a facility's services/charges change, during the course of a resident's stay, this information is also provided to residents and/or legal representatives in a written form. A written receipt of this information would be expected and should be in the resident's file.

Is this written receipt to be signed by resident and/or legal representative?

The "receipt" should be signed by the resident if he or she is competent to sign. In the case of a confused or disoriented resident or incompetent resident the responsible party should sign. If there is any question as to the resident's competency it is recommended that both the resident and responsible party sign the receipt.

If "yes", when representative of disoriented resident is out of town and does not return written receipt, what alternative can the facility use? Is it adequate for the facility to document, in the resident's file, that the facility notified resident and/or legal representative?

If a facility has not received a "receipt" from a "legal representative", it is appropriate to send another copy. It can be sent by certified mail. Documentation should then be made in the resident's chart as the continuing status of the requests

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FILE TOPIC: Resident Rights

Federal regulations at 42 CFR §483.10(b)(1) provide that a "facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility."

Please identify the "rights" of which the resident must be informed.

The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights found at 42 CFR §483.10, §483.12, §483.13, and §483.15.

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FILE TOPIC: Resident Rights

Is a resident's memory or recall of having been advised of the rights listed in 42 CFR §483.10(b) the only evidence a surveyor should consider in determining whether the facility advised the resident of these rights?

No, the surveyor also looks at documentation, such as the admissions packet information that the resident signed when he/she was admitted to the facility. The group is asked about resident rights and how the home facilitates this for residents. Other residents are also interviewed about resident rights on how these are acknowledged and implemented. Surveyors also observe how the facility interacts with residents and determine if resident rights are operationalized daily.

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FILE TOPIC: Resident Rights

Does the phrase "in a language that the resident understands" in 42 CFR §483.10(b) mean that facilities must give the statement of resident rights in language taken directly from the regulations or may the facility paraphrase or restate this language for the resident?

The interpretive guideline for this section states that this phrase means the language regarding rights and responsibilities must be clear and understandable. Some facilities and surveyors have felt in the past that residents must be given a verbatim statement of all resident rights using the regulatory language itself. However, to ensure that residents receive this information in a language they can understand, facilities are free to paraphrase the regulations and restate them in layman's language. There is no requirement that facilities give residents an exact verbatim copy of all resident rights in the same language used in the regulations.

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FILE TOPIC: Resident Rights

42 CFR §483.10(b) refers to "all rules and regulations governing resident conduct and responsibilities during the stay in the facility?" Does this refer to a body of law or to internal facility rules and regulations?

According to the interpretive guideline accompanying this regulation, the phrase "all rules and regulations governing resident conduct and responsibilities during the stay in the facility" refers to facility policy or facility rules governing resident conduct while in the facility. This phrase does not refer to any body of laws or regulations. It simply means that residents have the right to be notified of policies or rules which they will be expected to honor while residing in the facility.

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FILE TOPIC: Resident Rights

When advising residents of what services are covered under the Medicaid or Medicare program, is it sufficient if the facility clearly tells the resident what is not covered (i.e., what services the resident will be responsible for) and provides the resident with a statement that all other services are covered by the Medicare or Medicaid program?

Yes.

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FILE TOPIC: Resident Rights

Is it a violation of resident rights to post the resident plan of care schedule in the facility newsletter or public places within the facility such as bulletin boards?

Posting the dates of the residents' plan of care schedule within the facility does not constitute a violation of resident rights.

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FILE TOPIC: Resident Rights

Can providers prohibit smoking in nursing facilities?

Yes. Please see 131E-114.3 - Smoking prohibited inside long-term care facilities.

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FILE TOPIC: Resident Rights

When surveyors ask for recent transfers, should the list include room changes within the same certified unit?

No.

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FILE TOPIC: Resident Rights

Does the resident's right to refuse treatment include the refusal of a therapeutic diet? Also, if the resident has cognitive loss, can the responsible party request that a therapeutic diet be changed to a regular diet?

The resident has a right to refuse treatment, to refuse to participate in experimental research and to formulate an advanced directive.

The resident's right to refuse treatment includes the right to refuse a therapeutic diet. When a resident refuses treatment, the facility should clearly document: the refusal to reflect the resident's choice, discussion and education regarding the risks of refusing prescribed treatment, and the exploration of alternative therapies. The implications of the refusal should be evaluated by the facility to determine the need for reassessment and modification to the care plan.

A resident or the responsible party (if the resident cannot make a decision), may request a change in therapeutic diet to a regular diet. Ultimately, any changes in the diet must be approved by the physician.

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FILE TOPIC: Resident Rights

Can a facility charge a Medicare, Medicaid, private pay resident for pre-admission bed-hold days, and for bed-hold days if hospitalized?

The facility may not charge pre-admission bed-hold for Medicaid eligible residents. According to 483.12(d)(3), pre-admission bed-hold charges are prohibited. CMS has no jurisdiction regarding private pay residents.

The facility may charge for bed-hold charges if hospitalized. According to 483.12(b), bed hold policy, charges for a resident who is in the hospital may be paid by the resident or others on the resident's behalf. However, if a Medicaid recipient or surrogate chooses not to pay for the bed-hold, then the resident still has the right to be readmitted by the facility immediately upon the first availability of a bed [42 CFR §483.12(b)(3)]. Bedhold charges per se do not apply to private paying residents—individual facility policy should address how collection of monies are handled for private paying residents who are hospitalized.

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FILE TOPIC: Resident Rights

Situation: A resident who has not been declared incompetent and has a long standing diagnosis of Schizophrenia is increasingly noncompliant with physicians' orders to the degree that other residents are complaining that their rights are being violated. The resident refuses any form of hygienic care.

1. Are there any special guidelines or procedures to follow when this resident would be homeless if discharged?

The facility should involve the resident, the resident's representative, the entire interdisciplinary team and the physician to work out a plan to deal with these behaviors and address any medication changes. This is not a reason for discharge.

2. Should a PASARR for change in condition be completed?

A PASARR should be completed to reflect a significant change in the resident's behavior and request a Level II screening be completed by mental health. The facility can also petition to the court to have the resident evaluated for commitment procedures.

3. How can a behavior modification program be implemented when the resident will not comply? To what extent can privileges be withheld or rewards utilized in the long term setting?

Behavior modification programs which include withholding of privileges and offering rewards are appropriate in a long term care setting when thorough assessment has been accomplished and a care plan devised for that behavior modification by an appropriate interdisciplinary team. This interdisciplinary team should include a mental health professional when at all possible. The facility team should also consider psychiatric hospitalization to help stabilize the resident.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

How should facility staff handle surveyor requests to enter resident care areas while care is being provided? What should facility staff do if the surveyor wants to examine a particular part of the resident's anatomy?

Residents have the right to be treated in a manner that protects the privacy and dignity of their bodies. Facility staff should protect a resident's privacy and dignity at all times, including those times when a survey team is in the facility.

- Interviews by surveyors. If a surveyor asks to interview a resident or staff member at a time when the resident is undressed, the staff member should request that the surveyor return later when the resident is clothed. Surveyors should not ask to interview residents who are undressed.

- Surveyor asks to observe possible quality of care problem not readily observable. When indicators exist suggesting a quality of care problem that is not readily observable (e.g., leg ulcer covered with a dressing, or a sacral pressure sore), the surveyor should ask for facility staff to assist in making an observation by removing, for example, a dressing or bedclothes. However, if the procedure has the potential to cause pain or discomfort, the surveyor should wait until the next scheduled time of treatment. Such resident care observations should be made by surveyors who have the clinical knowledge and skills to evaluate compliance.

- Surveyor observations of resident's genital or rectal area or female breast area. If a surveyor asks to observe a resident's genital or rectal area or a female breast area to confirm and document suspicions of a care problem, a member of the facility's nursing staff must be present and the resident must give clear consent (see below). Also, only a surveyor who is a licensed nurse, a physician's assistant or a physician can make observations of this type.

- Consent for observations of genital, rectal or female breast area. For a surveyor to observe any of these areas, the resident must give clear consent. If the resident is unable to give consent (e.g., is unresponsive or incompetent) and has a legal surrogate (family member who can act on resident's behalf or other legal surrogate), the surveyor should ask this person to give consent. If there is no consent given by the resident or legal surrogate, a surveyor may only observe a resident's genital, rectal or female breast area if the surveyor has determined there is a strong possibility that the resident is receiving less than adequate care which can only be confirmed by direct observation.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Does the resident have the right to choose his/her own pharmacy and how often can he/she change that request?

The facility is to develop and implement policies and procedures regarding the drug distribution system. The resident should have the right to choose his/her own pharmacy if the dispensed product is compatible with the system employed in the facility and properly labeled. The facility is ultimately responsible for ensuring that medications are available. Frequency of change is not regulated, but is determined by facility policy to assure ongoing availability of drugs.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Can a family council deny membership to their council because a resident's family member is also an employee of the facility?

The resident is a beneficiary and is entitled to all rights afforded other residents. An employee related to a resident must participate as a family representative, not as a staff member.

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FILE TOPIC: Resident Rights

42 CFR §483.10(n) states that a resident has the right to share a room with his or her spouse when married residents live in the facility and both consent to the arrangement. However, if only one spouse is physically and/or mentally able to consent to rooming together, do the spouses have the right to room together?

Yes. Married couples have the right to room together, even if only one spouse is physically/mentally able to consent.

Would it matter if the family members for either spouse did not want the spouses to room together? Assume for the purposes of the question that the incompetent resident does not have a guardian.

No. The opinions of family members are of no legal consequence unless there is good reason to believe that the health or safety of the incompetent spouse would be jeopardized. The facility should pursue this type of problem utilizing the care planning process.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident's Rights

Does the licensure rule regarding the reporting and investigation of abuse, neglect, and misappropriation apply only to suspected staff abuse, or does it also apply to resident-to-resident abuse?

The licensure rule requiring reporting of abuse to the DHSR Health Care Personnel Registry Section is limited to allegation of staff abuse, neglect or misappropriation. There is no requirement to report resident-to-resident abuse, neglect or misappropriation to DHSR. However, the facility is responsible for identifying and investigating all incidents of suspected resident abuse, neglect or misappropriation whether by staff or others (including resident-to-resident abuse).

The administrator shall ensure that the Health Care Personnel Registry Section of the Division of Health Service Regulation is notified within 24 hours of the health care facility becoming aware of all allegations against health care personnel as defined in G.S. 131E-256 (a)(1), which includes~~:~~ abuse, neglect, misappropriation of resident property, misappropriation of the property of the facility, diversion of drugs belonging to a health care facility or a resident, fraud against a health care facility or a resident, and injuries of unknown source in accordance with 42 CFR subsection 483.13 which is incorporated by reference.

DHSR has developed a reporting form for facilities to use. It is available online at www.ncnar.org. The facility must make its report to DHSR within five working days of the date the facility becomes aware of the alleged incident.

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FILE TOPIC: Resident Rights

When a DHSR team is conducting a survey, can residents in Medicare and/or Medicaid beds deny access of their records to surveyors?

No. According to federal regulations, a nursing facility can be terminated from the Medicare/Medicaid program if it refuses examination of records necessary for verification of information it furnished as a basis for payment under Medicare 42 CFR §489.53(5) and under Medicaid as a part of the Medicaid agreement with the facility. Since a fundamental prerequisite for payment to a nursing home under Medicare/Medicaid is compliance with requirements for participation, CMS's authority and/or the Medicaid agency's authority to terminate under these regulations extends to the facility's cooperation with the survey agency's certification activities.

State law allows a resident to object in writing to inspection of his/her record by DHSR. However, federal law supersedes state law when a resident is in a Medicare and/or Medicaid certified bed.

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FILE TOPIC: Resident Rights

What is the nursing home's responsibility in providing information to residents about Medicaid's spousal impoverishment rules?

The facility should advise the resident to contact the local department of social services for information about spousal impoverishment. The facility should provide the resident with that agency's telephone number and, if needed, assist the resident in contacting the agency.

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FILE TOPIC: Resident Rights

Under federal law, movement of a resident from one room to another within the same certified facility is not considered a "transfer or discharge" but is considered a roommate change. Under federal law, roommate changes are not subject to the 30-day notice requirement applicable to transfers or discharges. Instead, residents must only be given "prompt" notice. However, the North Carolina Patient Bill of Rights at N.C. G.S. 131E-117(15) requires at least a 5-day advance notice to the resident before a transfer or discharge and the interpretive guideline states that this includes movement of a resident from one location to another within the facility. Does this mean the facility must give residents a five-day notice even where the relocation is only a roommate change under federal law and is not a transfer or discharge?

No. G.S. 131E-117(15) requires at least five days' notice before a transfer or discharge (unless an earlier transfer or discharge is ordered by the attending physician). However, the North Carolina statute does not define a "transfer or discharge" to include movement of residents from one room to another within the same facility (i.e., roommate changes). Nor do any applicable state regulations define transfer or discharge to include movement of residents within the same facility. Therefore, there is no statutory or regulatory basis in state law for equating a roommate change with a transfer or discharge or for requiring a 5-day notice for roommate changes. Therefore, if a facility determines that a planned move of a resident is a roommate change and not a transfer or discharge under federal law, the facility must only give "prompt" notice (which is not defined as a prescribed number of days) and the North Carolina statute does not require a minimum five days' notice. If the facility determines that the move is a transfer or discharge, it must honor the federal 30-day notice requirement (unless an exception applies under federal law). In so doing, the facility will automatically meet the state's less stringent 5-day notice requirement for transfers and discharges. A non-certified facility or unit (not required to follow the federal requirements) must give the resident a 5-day notice prior to a transfer or discharge, but is not required to give such notice prior to a roommate change.

It should be noted, however, that federal law does define transfer or discharge to include some roommate changes if the relocation of the resident is across distinct part lines (with some exceptions). All North Carolina facilities which are certified for participation in either the Medicaid or Medicare programs are subject to the federal rules on transfer and discharge, and must comply with federal limits on transfers and discharges in certified beds. The only facilities which are exempt from the federal requirements are those which are not certified for participation in the Medicaid or Medicare programs (this may include the noncertified portion of a facility with certified beds).

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

We understand that a resident rights issue exists when a resident is constantly yelling and this behavior is disruptive to the normal daily routine of other residents on her unit and in the facility. What are the guidelines that a facility needs to follow to protect the rights of the other residents?

The rights of other residents include the rights to be treated with consideration, respect, and full recognition of personal dignity; to receive care, treatment and services which are adequate and appropriate; to be free from mental and physical abuse; and to associate and communicate privately and without restriction. The facility must attempt to assess the reason for the behavior, including a complete resident assessment utilizing the appropriate resident assessment protocols (RAPs) to determine the underlying problems (e.g., potential pain the resident is unable to communicate). Causal factors should be relieved whenever possible.

The yelling resident's rights should be balanced against the rights of other residents to peaceful living conditions. If an assessment has been completed, and all possible ways of dealing with the disruptive resident have been exhausted, it may be necessary to transfer or discharge the resident under the regulations found at 42 CFR §483.12 Admission, Discharge and Transfer Rights. Thorough documentation in the medical record of the results of assessment, interventions, etc. is essential.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

When a resident requests a discharge to another facility or movement outside of a distinct part to another location in the facility (e.g., from a Medicare/Medicaid bed to a Medicaid bed) are notice of discharge and appeal rights forms required?

No. According to DMA: "Transfer and discharge requirements at section 42 CFR §483.12(a) apply when the facility initiates the transfer or discharge. The purposes of the requirements are to insure that residents remain in the facility in the absence of any of the six criteria at section 42 CFR §483.12(a)(2), and to inform residents of their rights to question the decision of the facility relating to their transfer/discharge. If a resident or resident's legal representative initiates a transfer or discharge voluntarily, then these requirements do not apply."

When there are questions regarding specific cases, providers should contact their own attorneys or the attorney for the North Carolina Health Care Facility Association as the DMA Hearing Unit cannot engage in ex parte conversations about how to give notice of transfer/discharge to a specific resident, nor can they give legal advice. Transfer/Discharge hearings are evidentiary hearings in the sense that witnesses are sworn and the hearing is recorded.

In some cases, providers have lost hearings because of technicalities. In order to make sure cases are not lost due to technicalities, providers should be very familiar with transfer/discharge regulations and any other regulations pertaining to discharge planning. Regulations that speak to transfer/discharge and planning include: 483.10 (o); 483.12(a-b); 483.15 (g)(1) and; 483.20(e).

In addition, providers should make sure that assessments, care plans and other documents that may be relative to the transfer/discharge issues accurately reflect the resident's condition. For example, if a resident is jeopardizing the health and welfare of other residents, this should be reflected in appropriate assessment data and goal planning. There should be clear documented evidence that the resident is endangering others.

In an emergency situation, like transfer to a hospital, if appeal rights and forms cannot be transported with the resident or the resident has a legal guardian, then the appropriate information should be provided as soon as possible. For example, if the resident leaves the facility late at night, then the information can be sent the next day.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

On rare occasions it is not safe or practical for a resident to have a call bell within complete access. Examples: a resident who wraps the cord around their neck, a resident who wraps it around their arm causing skin tears, or a resident who is completely incapable of using the system as testified to by the physician, family, and caregivers. Can a facility restrict complete access to a call bell under certain circumstances if they develop a policy addressing this issue?

Each resident's ability to have access to the call bell should be reviewed by the resident's care planning committee. When the call bell becomes a safety issue for the resident, or the resident's level of orientation renders him/her unable to understand its use, access should be limited and other methods of assuring communication and safety should be identified.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Is it a violation of resident's rights for a surveyor to mark the diaper (waistband closure) or underpad in order to monitor the care of the incontinent resident?

We teach surveyors to make observations of care and monitor via observation over time. We do not mark incontinence products.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Does failure to complete any of lines one through eight on the Notice of Transfer or Discharge form automatically invalidate the planned transfer or discharge?

Yes. The resident has the right not to be transferred or discharged unless the proper notice is given. 10 NCAC 26I .0302(b), regarding Transfer and Discharge Requirements states that, "Failure to complete the Notice of Transfer or Discharge form shall result in the notice of transfer or discharge being ineffective."

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

We are concerned about our residents that are transferred by EMS and other resident transport services, and are out of the building for an extended length of time. Can we be cited for issues involving personal care while they are with the transport service?

The Division of Health Service Regulation Nursing Home Licensure and Certification Section does not regulate EMS. However, when arrangements are provided under private service agreements, the facility assumes responsibility for meeting the needs of the resident and should include their expectation for the provision of care in the agreement made with the transport service.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Does tag # 174 require the facility to install a cordless telephone?

No.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Is it necessary to always revisit the resident/family information about Advance Directives and the Do Not Resuscitate order when residents are re-admitted to the facility? Would this be determined by how long they are away from the facility before return, or would this be determined by a change in status? How would you define a "change in status?" Is there is a federal requirement that readmissions be "re-given" the admission packet, inclusive of the Do Not Resuscitate order?

Facility policy should address how the facility will treat re-admissions to their facility in regard to advance directives. Refer to interpretive guidance for §483.10(b)(8). DNR orders are not expressly regulated under §483.10(b)(8). The physician writes DNR orders. The facility should have policies regarding the establishment of such orders and when those orders need to be revised based on State law.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Who is the legal surrogate decision-maker for medical treatment choices when a resident is cognitively impaired and has not named a formal health care power of attorney or written a living will?

Ethical guidelines consistently endorse the use of family surrogates to make health care decisions when a resident is cognitively impaired. Procedures for Natural Death in the Absence of a Declaration (§ 90-322) indicates a sequence of family surrogate authority -- a legal guardian, or a spouse, or a majority of relatives of the first degree. This sequence is natural for many families, and should be used in cases of terminal and incurable illness or persistent vegetative state. In other health conditions, the law is not specific, but ethical guidelines and clinical best practices endorse the use of family surrogates who have the best knowledge of the resident's own values and preferences.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Is a facility required to accommodate resident food requests outside the routine items ordered for menus? For example: If a resident requests raw broccoli and cauliflower, but the facility does not usually carry the item in stock, are we required to make an individual purchase for that resident or can we ask the family to provide special requests such as this? If 100 residents all had individual requests, where is the cut-off for accommodating preferences?

If the facility can easily accommodate the food request, then it should be honored. It is not expected that the facility has to order a case of raw broccoli to accommodate the resident or make a special trip to the grocery store to purchase the broccoli. Families can be asked to bring in food items that are not a part of the routine items ordered for menus. If many residents are making individual requests, then the facility should establish a resident committee, or use the resident's council to review menu items and make recommendations to establish new menus.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Is it a breach of confidentiality to post a resident's name outside the room next to the entry to the room?

No. However, if the resident or the resident's legal representative/responsible party does not want his/her name posted, then the facility should accommodate the request.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

Page reserved.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

A resident is ready for discharge from the hospital back to the nursing home, but there are no beds available for the resident and he/she has to be transferred to another nursing home. Does this resident have the right to the first bed opening in the original nursing home?

Yes, the resident has the right to return to the original nursing facility even if they have been placed into another nursing home. The facility should notify the resident/family of the availability of the bed at the original nursing home. If the resident refuses the bed and chooses to stay at the other facility, then that would end satisfy the requirement and no further offer would need to be made.

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

If survey results are available in public areas without any restriction to access, must the facility also post a notice of the location of these documents?

Yes. Regulation 483.10(g)(11) requires the facility to "make the results available for examination in a place readily accessible to residents and must post a notice of their availability (F167)."

REGULATORY FOCUS BULLETIN

FILE TOPIC: Resident Rights

If a resident is discharged/transferred to the emergency room or hospital must a notice of discharge be issued?

Yes. Although it is not possible to give the 30-day notice, the federal regulation found at F203 requires that a notice with specified content "be made as soon as practicable" for an "immediate transfer" due to an "urgent medical need."

The 2016 Florida Statutes

PUBLIC HEALTH NURSING HOMES AND RELATED HEALTH CARE FACILITIES

400.022 Residents' rights.—

(1) All licensees of nursing home facilities shall adopt and make public a statement of the rights and responsibilities of the residents of such facilities and shall treat such residents in accordance with the provisions of that statement. The statement shall assure each resident the following:

(a) The right to civil and religious liberties, including knowledge of available choices and the right to independent personal decision, which will not be infringed upon, and the right to encouragement and assistance from the staff of the facility in the fullest possible exercise of these rights.

(b) The right to private and uncensored communication, including, but not limited to, receiving and sending unopened correspondence, access to a telephone, visiting with any person of the resident's choice during visiting hours, and overnight visitation outside the facility with family and friends in accordance with facility policies, physician orders, and Title XVIII (Medicare) and Title XIX (Medicaid) of the Social Security Act regulations, without the resident's losing his or her bed. Facility visiting hours shall be flexible, taking into consideration special circumstances such as, but not limited to, out-of-town visitors and working relatives or friends. Unless otherwise indicated in the resident care plan, the licensee shall, with the consent of the resident and in accordance with policies approved by the agency, permit recognized volunteer groups, representatives of community-based legal, social, mental health, and leisure programs, and members of the clergy access to the facility during visiting hours for the purpose of visiting with and providing services to any resident.

(c) Any entity or individual that provides health, social, legal, or other services to a resident has the right to have reasonable access to the resident. The resident has the right to deny or withdraw consent to access at any time by any entity or individual. Notwithstanding the visiting policy of the facility, the following individuals must be permitted immediate access to the resident:

1. Any representative of the federal or state government, including, but not limited to, representatives of the Department of Children and Families, the Department of Health, the Agency for Health Care Administration, the Office of the Attorney General, and the Department of Elderly Affairs; any law enforcement officer; any representative of the State Long-Term Care Ombudsman Program; and the resident's individual physician.

2. Subject to the resident's right to deny or withdraw consent, immediate family or other relatives of the resident.

The facility must allow representatives of the State Long-Term Care Ombudsman Program to examine a resident's clinical records with the permission of the resident or the resident's legal representative and consistent with state law.

(d) The right to present grievances on behalf of himself or herself or others to the staff or administrator of the facility, to governmental officials, or to any other person; to recommend changes in policies and services to facility personnel; and to join with other residents or individuals within or outside the facility to work for improvements in resident care, free from restraint, interference, coercion, discrimination, or reprisal. This right includes access to ombudsmen and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. The right also includes the right to prompt efforts by the facility to resolve resident grievances, including grievances with respect to the behavior of other residents.

(e) The right to organize and participate in resident groups in the facility and the right to have the resident's family meet in the facility with the families of other residents.

(f) The right to participate in social, religious, and community activities that do not interfere with the rights of other residents.

(g) The right to examine, upon reasonable request, the results of the most recent inspection of the facility conducted by a federal or state agency and any plan of correction in effect with respect to the facility.

(h) The right to manage his or her own financial affairs or to delegate such responsibility to the licensee, but only to the extent of the funds held in trust by the licensee for the resident. A quarterly accounting of any transactions made on behalf of the resident shall be furnished to the resident or the person responsible for the resident. The facility may not require a resident to deposit personal funds with the facility. However, upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility as follows:

1. The facility must establish and maintain a system that ensures a full, complete, and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

2. The accounting system established and maintained by the facility must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

3. A quarterly accounting of any transaction made on behalf of the resident shall be furnished to the resident or the person responsible for the resident.

4. Upon the death of a resident with personal funds deposited with the facility, the facility must convey within 30 days the resident's funds, including interest, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate, or, if a personal representative has not been appointed within 30 days, to the resident's spouse or adult next of kin named in the beneficiary designation form provided for in s. 400.162(6).

5. The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under Title XVIII or Title XIX of the Social Security Act.

(i) The right to be fully informed, in writing and orally, prior to or at the time of admission and during his or her stay, of services available in the facility and of related charges for such services, including any charges for services not covered under Title XVIII or Title XIX of the Social Security Act or not covered by the basic per diem rates and of bed reservation and refund policies of the facility.

(j) The right to be adequately informed of his or her medical condition and proposed treatment, unless the resident is determined to be unable to provide informed consent under Florida law, or the right to be fully informed in advance of any nonemergency changes in care or treatment that may affect the resident's well-being; and, except with respect to a resident adjudged incompetent, the right to participate in the planning of all medical treatment, including the right to refuse medication and treatment, unless otherwise indicated by the resident's physician; and to know the consequences of such actions.

(k) The right to refuse medication or treatment and to be informed of the consequences of such decisions, unless determined unable to provide informed consent under state law. When the resident refuses medication or treatment, the nursing home facility must notify the resident or the resident's legal representative of the consequences of such decision and must document the resident's decision in his or her medical record. The nursing home facility must continue to provide other services the resident agrees to in accordance with the resident's care plan.

(l) The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency.

(m) The right to have privacy in treatment and in caring for personal needs; to close room doors and to have facility personnel knock before entering the room, except in the case of an emergency or unless medically contraindicated; and to security in storing and using personal possessions. Privacy of the resident's body shall be

maintained during, but not limited to, toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. Residents' personal and medical records shall be confidential and exempt from the provisions of s. 119.07(1).

(n) The right to be treated courteously, fairly, and with the fullest measure of dignity and to receive a written statement and an oral explanation of the services provided by the licensee, including those required to be offered on an as-needed basis.

(o) The right to be free from mental and physical abuse, corporal punishment, extended involuntary seclusion, and from physical and chemical restraints, except those restraints authorized in writing by a physician for a specified and limited period of time or as are necessitated by an emergency. In case of an emergency, restraint may be applied only by a qualified licensed nurse who shall set forth in writing the circumstances requiring the use of restraint, and, in the case of use of a chemical restraint, a physician shall be consulted immediately thereafter. Restraints may not be used in lieu of staff supervision or merely for staff convenience, for punishment, or for reasons other than resident protection or safety.

(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, or in the case of conflicting rules and regulations which govern Title XVIII or Title XIX of the Social Security Act. For nonpayment of a bill for care received, the resident shall be given 30 days' advance notice. A licensee certified to provide services under Title XIX of the Social Security Act may not transfer or discharge a resident solely because the source of payment for care changes. Admission to a nursing home facility operated by a licensee certified to provide services under Title XIX of the Social Security Act may not be conditioned upon a waiver of such right, and any document or provision in a document which purports to waive or preclude such right is void and unenforceable. Any licensee certified to provide services under Title XIX of the Social Security Act that obtains or attempts to obtain such a waiver from a resident or potential resident shall be construed to have violated the resident's rights as established herein and is subject to disciplinary action as provided in subsection (3). The resident and the family or representative of the resident shall be consulted in choosing another facility.

(q) The right to freedom of choice in selecting a personal physician; to obtain pharmaceutical supplies and services from a pharmacy of the resident's choice, at the resident's own expense or through Title XIX of the Social Security Act; and to obtain information about, and to participate in, community-based activities programs, unless medically contraindicated as documented by a physician in the resident's medical record. If a resident chooses to use a community pharmacy and the facility in which the resident resides uses a unit-dose system, the pharmacy selected by the resident shall be one that provides a compatible unit-dose system, provides service delivery, and stocks the drugs normally used by long-term care residents. If a resident chooses to use a community pharmacy and the facility in which the resident resides does not use a unit-dose system, the pharmacy selected by the resident shall be one that provides service delivery and stocks the drugs normally used by long-term care residents.

(r) The right to retain and use personal clothing and possessions as space permits, unless to do so would infringe upon the rights of other residents or unless medically contraindicated as documented in the resident's medical record by a physician. If clothing is provided to the resident by the licensee, it shall be of reasonable fit.

(s) The right to have copies of the rules and regulations of the facility and an explanation of the responsibility of the resident to obey all reasonable rules and regulations of the facility and to respect the personal rights and private property of the other residents.

(t) The right to receive notice before the room of the resident in the facility is changed.

(u) The right to be informed of the bed reservation policy for a hospitalization. The nursing home shall inform a private-pay resident and his or her responsible party that his or her bed will be reserved for any single hospitalization for a period up to 30 days provided the nursing home receives reimbursement. Any resident who is a recipient of assistance under Title XIX of the Social Security Act, or the resident's designee or legal representative, shall be informed by the licensee that his or her bed will be reserved for any single hospitalization for the length of time for which Title XIX reimbursement is available, up to 15 days; but that the bed will not be reserved if it is medically determined by the agency that the resident will not need it or will not be able to return to the nursing

home, or if the agency determines that the nursing home's occupancy rate ensures the availability of a bed for the resident. Notice shall be provided within 24 hours of the hospitalization.

(v) For residents of Medicaid or Medicare certified facilities, the right to challenge a decision by the facility to discharge or transfer the resident, as required under 42 C.F.R. s. 483.12.

(2) The licensee for each nursing home shall orally inform the resident of the resident's rights and provide a copy of the statement required by subsection (1) to each resident or the resident's legal representative at or before the resident's admission to a facility. The licensee shall provide a copy of the resident's rights to each staff member of the facility. Each such licensee shall prepare a written plan and provide appropriate staff training to implement the provisions of this section. The written statement of rights must include a statement that a resident may file a complaint with the agency or state or local ombudsman council. The statement must be in boldfaced type and include the telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone numbers of the local ombudsman council and the Elder Abuse Hotline operated by the Department of Children and Families.

(3) Any violation of the resident's rights set forth in this section constitutes grounds for action by the agency under s. 400.102, s. 400.121, or part II of chapter 408. In order to determine whether the licensee is adequately protecting residents' rights, the licensure inspection of the facility must include private informal conversations with a sample of residents to discuss residents' experiences within the facility with respect to rights specified in this section and general compliance with standards and consultation with the State Long-Term Care Ombudsman Program.

(4) Any person who submits or reports a complaint concerning a suspected violation of the resident's rights or concerning services or conditions in a facility or who testifies in any administrative or judicial proceeding arising from such complaint shall have immunity from any criminal or civil liability therefor, unless that person has acted in bad faith, with malicious purpose, or if the court finds that there was a complete absence of a justiciable issue of either law or fact raised by the losing party.

"This course was developed from the public domain documents: The 2016 Florida Statutes and Federal Law Resident Rights – The Florida Legislature, U.S. Government."