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EXHIBIT 7
DATE 2-5-07
HB 471

HOUSE BUSINESS AND LABOR COMMITTEE

HOUSE BILL 471

90-DAY NOTICE OF "RENT" AND FEE INCREASES

For the record, I am Rose Hughes, Executive Director of the Montana Health Care Association, an association that represents nursing homes and assisted living facilities throughout the state of Montana.

We oppose House Bill 471.

In general, HB 471 requires ICF/DD facilities, assisted living facilities and long term care facilities to provide 90-day notice before increasing any rent or fees. It also provides that these facilities may not require more than 30-day notice from a resident who is moving out of the facility. The way the bill is drafted, what it requires for each group is a little different.

For assisted living and ICF/DD, the 90-day notice applies to "rent or fee increases". For long term care facilities, it applies to "any changes in the cost or availability of services" - which is actually broader than "rent or fees".

Adding to the confusion is that the statutory definition of "long term care facility" is quite broad. It includes skilled nursing care, residential care, intermediate nursing care, and ICF/DD care. It also includes adult day care, adult foster care homes, assisted living facilities, and retirement homes as they are all part of the definition of "residential care facility". (50-5-101, MCA)

So, the net effect, is that all of the covered facilities will have to meet the broader scope of this bill found in section 3, which amends 50-5-1104 relating to long term care facilities.

In addition to the technical problems with this legislation, we oppose its general intent to require 90 days advance notice of "any changes in the cost or availability of services". I will confine my remarks to nursing homes and assisted living facilities.

Reasons for opposition:

1. Nursing homes and assisted living facilities are health care facilities - they are not entities

that simply rent apartments out to people. In the case of nursing homes, they do not separate out the "rent". The per day charge is based on all services provided to the resident.

2. The rates charged by nursing homes and assisted living facilities are normally based on an extensive budgeting process. Budgets are not finalized 90 days in advance of the rate year, nor should they be, since they must be based on as much current information as possible. For nursing homes, a significant part of the budget - in terms of the income side of the equation - is the Medicaid rate to be received by the facility. For many reasons, nursing homes' annual rate increases are normally effective July 1 - in keeping with the state fiscal year. This is because changes in Medicaid rates come in to play in terms of how much revenue can be expected from Medicaid residents. Also, any special programs, such as the direct care wage increase approved in 2005 are also effective July 1. For nursing homes, in a legislative year, they would have to be involved in their budgeting process in February and March and give notice of their rates by April 1 - long before the legislature has adopted a budget for nursing homes and long before we can know what will be included in our Medicaid rates.
3. Some facilities charge based on level of care. In other words, those with lower care needs pay less, and those needing more services pay more. If a relatively mobile assisted living resident falls and breaks a hip or leg, that individual will return to the facility with much greater care needs than were previously required. It is not appropriate for the facility to wait 90 days to start being paid for the new level of care. In smaller facilities, a significant change in one resident's care could necessitate additional staff. Of course, a resident whose condition has improved would not like to wait 90 days to receive the lower rate, either.
4. Residents and their families know at the time of admission how rate increases will be handled. For both nursing homes and assisted living facilities, there are admission agreements, which outline services and charges and the process for changing services and charges. Facilities have a business relationship with their residents. The business relationship includes a contract which lays out what is expected of both parties and both parties agree to the terms, notice requirements, etc., up front.
5. Residents and their families "shop" around before they choose a facility. Their choice of facility - in those communities where there are several facilities to choose from - is based on many factors including cost, staffing ratios, size, location, reputation, etc. If the resident and family are satisfied with the care and services received once admitted to the facility, they are very unlikely to move out - regardless of price increases. I have visited with many facilities about this issue and am told that a price increase is almost never the reason for a resident to leave a facility.
6. Giving 90 days' notice of the availability of services is also problematic. What if a

facility is having problems staffing or filling its Alzheimer's unit? Should it be forced to keep it open 90 days after it has concluded it should close?

HB 471 is an unnecessary intrusion into the business practices of private businesses. And, it doesn't solve the problem it is aimed at.

People don't like it when the price of anything goes up. But the cost of care in these facilities does go up. Our costs are driven by a staffing crisis, where we're having to raise wages far above the typical 3-5% that you might consider normal inflation. We are also subject to other price increases - whether for paper products, energy, fuel for our vans, food, etc. As legislators you are not able to shield our residents from price increases. An individual facility's price is going to go up, and chances are that the facility down the road will also increase its prices. No amount of notices solves this problem

Also, this legislation might actually hurt the very people its trying to help. For example, a facility forced to do its budget 120-150 days out in order to give 90 days' notice, will be doing more "guess work". It makes sense to think that if they are less certain about their income and expenses they are going to add in a "cushion" to be sure the rates are sufficient. Residents could actually end up paying higher rates because of this legislation. Also, facilities that try to individualize the cost of services - charging for level of care, for example - may decide that giving 90 days' notice doesn't work. They could very well end up charging everyone at a higher level that doesn't need to go up or down with change of condition. In other words, if this legislation adversely affects facilities, they will change their practices to minimize the adverse affects. They have no choice but to do what's required to assure the financial viability of the business.

HB 471 is not needed and will not solve the problem it seeks to address. However, it will cause problems for nursing homes and assisted living facilities all over the state, many of which (especially in our rural areas) struggle to keep their doors open.

I urge you to vote "do not pass" on HB 471.

37.106.2823 RESIDENT AGREEMENT (1) An assisted living facility shall enter into a written resident agreement with each prospective resident prior to admission to the assisted living facility. The agreement shall be signed and dated by a facility representative and the prospective resident or the resident's legal representative. The facility shall provide the prospective resident or the resident's legal representative and the resident's practitioner, if applicable, a copy of the agreement and shall explain the agreement to them. The agreement shall include at least the following items:

- (a) the criteria for requiring transfer or discharge of the resident to another level of care;
- (b) a statement explaining the availability of skilled nursing or other professional services from a third party provider to a resident in the facility;
- (c) the extent that specific assistance will be provided by the facility as specified in the resident service plan;
- (d) a statement explaining the resident's responsibilities including but not limited to house rules, the facility grievance policy, facility smoking policy and policies regarding pets;
- (e) a listing of specific charges to be incurred for the resident's care, frequency of payment, facility rules relating to nonpayment of services and security deposits, if any are required;
- (f) a statement of all charges, fines, penalties or late fees that shall be assessed against the resident;
- (g) a statement that the agreed upon facility rate shall not be changed unless 30 day advance written notice is given to the resident and/or the resident's legal representative; and
- (h) an explanation of the assisted living facility's policy for refunding payment in the event of the resident's absence, discharge or transfer from the facility and the facility's policy for refunding security deposits.

(2) When there are changes in services, financial arrangements, or in requirements governing the resident's conduct and care, a new resident/provider agreement must be executed or the original agreement must be updated by addendum and signed and dated by the resident or the resident's legal representative and by the facility representative.

(History: Sec. 50-5-103, 50-5-226 and 50-5-227, MCA; IMP, Sec. 50-5-225, 50-5-226 and 50-5-227, MCA; NEW, 2002 MAR p. 3638, Eff. 12/27/02; AMD, 2004 MAR p. 1146, Eff. 5/7/04.)

37.106.2824 INVOLUNTARY DISCHARGE CRITERIA (1) Residents

shall be given a written 30 day notice when they are requested to move out. The administrator or designee shall initiate transfer of a resident through the resident's physician or practitioner, appropriate agencies, or the resident for resident's legal representative when:

- (a) the resident's needs exceed the level of ADL services the facility provides;
- (b) the resident exhibits behavior or actions that repeatedly and substantially interfere with the rights, health, safety or well being of other residents and the facility has tried prudent and reasonable interventions;
 - (i) documentation of the interventions attempted by the facility shall become part of the resident's record;
- (c) the resident, due to severe cognitive decline, is not able to respond to verbal instructions, recognize danger, make basic care decisions, express needs or summon assistance, except as permitted by ARM 37.106.2891 through 37.106.2898;
- (d) the resident has a medical condition that is complex, unstable or unpredictable and treatment cannot be appropriately developed in the assisted living environment;

patient's family arising out of physical, psychological, spiritual, social, and economic stresses experienced during the final stages of illness and dying and that includes formal bereavement programs as an essential component. The term includes:

(a) an inpatient hospice facility, which is a facility managed directly by a medicare-certified hospice that meets all medicare certification regulations for freestanding inpatient hospice facilities; and

(b) a residential hospice facility, which is a facility managed directly by a licensed hospice program that can house three or more hospice patients.

(28) (a) "Hospital" means a facility providing, by or under the supervision of licensed physicians, services for medical diagnosis, treatment, rehabilitation, and care of injured, disabled, or sick individuals. Services provided may or may not include obstetrical care, emergency care, or any other service allowed by state licensing authority. A hospital has an organized medical staff that is on call and available within 20 minutes, 24 hours a day, 7 days a week, and provides 24-hour nursing care by licensed registered nurses. The term includes hospitals specializing in providing health services for psychiatric, developmentally disabled, and tubercular patients.

(b) The term does not include critical access hospitals.

(29) "Infirmiry" means a facility located in a university, college, government institution, or industry for the treatment of the sick or injured, with the following subdefinitions:

(a) an "infirmiry—A" provides outpatient and inpatient care;

(b) an "infirmiry—B" provides outpatient care only.

(30) (a) "Intermediate care facility for the developmentally disabled" means a facility or part of a facility that provides intermediate developmental disability care for two or more persons.

(b) The term does not include community homes for persons with developmental disabilities that are licensed under 53-20-305 or community homes for persons with severe disabilities that are licensed under 52-4-203.

(31) "Intermediate developmental disability care" means the provision of intermediate nursing care services, health-related services, and social services for persons with a developmental disability, as defined in 53-20-102, or for persons with related problems.

(32) "Intermediate nursing care" means the provision of nursing care services, health-related services, and social services under the supervision of a licensed nurse to patients not requiring 24-hour nursing care.

(33) "Joint commission on accreditation of healthcare organizations" means the organization nationally recognized by that name that surveys health care facilities upon their requests and grants accreditation status to a health care facility that it finds meets its standards and requirements.

(34) "Licensed health care professional" means a licensed physician, physician assistant, advanced practice registered nurse, or registered nurse who is practicing within the scope of the license issued by the department of labor and industry.

(35) (a) "Long-term care facility" means a facility or part of a facility that provides skilled nursing care, residential care, intermediate nursing care, or intermediate developmental disability care to a total of two or more individuals or that provides personal care.

(b) The term does not include community homes for persons with developmental disabilities licensed under 53-20-305; community homes for persons with severe disabilities, licensed under 52-4-203; youth care facilities, licensed under 52-2-622; hotels, motels, boardinghouses, roominghouses, or similar accommodations providing for transients, students, or individuals who do not require institutional health care; or juvenile and adult correctional facilities operating under the authority of the department of corrections.

(36) "Medical assistance facility" means a facility that meets both of the following:

(a) provides inpatient care to ill or injured individuals before their transportation to a hospital or that provides inpatient medical care to individuals needing that care for a period of no longer than 96 hours unless a longer period is required because transfer to a hospital is precluded because of inclement weather or emergency conditions. The department or its designee may, upon request, waive the 96-hour restriction retroactively and on a case-by-case basis if the individual's attending physician, physician assistant, or nurse practitioner

determines that the transfer is medically inappropriate and would jeopardize the health and safety of the individual.

(36) "Facility" means either is located in a county with fewer than six residents a square mile or is located more than 35 road miles from the nearest hospital.

(37) "Mental health center" means a facility providing services for the prevention or diagnosis of mental illness, the care and treatment of mentally ill patients, the rehabilitation of mentally ill individuals, or any combination of these services.

(38) "Nonprofit health care facility" means a health care facility owned or operated by one or more nonprofit corporations or associations.

(39) "Offer" means the representation by a health care facility that it can provide specific health services.

(40) (a) "Outdoor behavioral program" means a program that provides treatment, rehabilitation, and prevention for behavioral problems that endanger the health, interpersonal relationships, or educational functions of a youth and that:

(i) serves either adjudicated or nonadjudicated youth;

(ii) charges a fee for its services; and

(iii) provides all or part of its services in the outdoors.

(b) "Outdoor behavioral program" does not include recreational programs such as boy scouts, girl scouts, 4-H clubs, or other similar organizations.

(41) "Outpatient center for primary care" means a facility that provides, under the direction of a licensed physician, either diagnosis or treatment, or both, to ambulatory patients and that is not an outpatient center for surgical services.

(42) "Outpatient center for surgical services" means a clinic, infirmary, or other institution or organization that is specifically designed and operated to provide surgical services to patients not requiring hospitalization and that may include recovery care beds.

(43) "Patient" means an individual obtaining services, including skilled nursing care, from a health care facility.

(44) "Person" means an individual, firm, partnership, association, organization, agency, institution, corporation, trust, estate, or governmental unit, whether organized for profit or not.

(45) "Personal care" means the provision of services and care for residents who need some assistance in performing the activities of daily living.

(46) "Practitioner" means an individual licensed by the department of labor and industry who has assessment, admission, and prescription authority.

(47) "Recovery care bed" means, except as provided in 50-5-235, a bed occupied for less than 24 hours by a patient recovering from surgery or other treatment.

(48) "Rehabilitation facility" means a facility that is operated for the primary purpose of assisting in the rehabilitation of disabled individuals by providing comprehensive medical evaluations and services, psychological and social services, or vocational evaluation and training or any combination of these services and in which the major portion of the services is furnished within the facility.

(49) "Resident" means an individual who is in a long-term care facility or in a residential care facility.

(50) "Residential care facility" means an adult day-care center, an adult foster care home, an assisted living facility, or a retirement home.

(51) "Residential psychiatric care" means active psychiatric treatment provided in a residential treatment facility to psychiatrically impaired individuals with persistent patterns of emotional, psychological, or behavioral dysfunction of such severity as to require 24-hour supervised care to adequately treat or remedy the individual's condition. Residential psychiatric care must be individualized and designed to achieve the patient's discharge to less restrictive levels of care at the earliest possible time.

(52) "Residential treatment facility" means a facility operated for the primary purpose of providing residential psychiatric care to individuals under 21 years of age.

(53) "Retirement home" means a building or buildings in which separate living accommodations are rented or leased to individuals who use those accommodations as their primary residence.

Federal regs

If a resident's refusal of treatment brings about a significant change, the facility should reassess the resident and institute care planning changes. A resident's refusal of treatment does not absolve a facility from providing a resident with care that allows him/her to attain or maintain his/her highest practicable physical, mental and psychosocial well-being in the context of making that refusal.

The resident has the right to refuse to participate in experimental research. A resident being considered for participation in experimental research must be fully informed of the nature of the experiment (e.g., medication, treatment) and understand the possible consequences of participating. The opportunity to refuse to participate in experimental research must occur prior to the start of the research. Aggregated resident statistics that do not identify individual residents may be used for studies without obtaining residents' permission.

Procedures §483.10(b)(4)

If the facility participates in any experimental research involving residents, does it have an Institutional Review Board or other committee that reviews and approves research protocols? In this regard, §483.75(c), Relationship to Other HHS Regulations applies (i.e., the facility must adhere to 45 CFR Part 46, Protection of Human Subjects of Research).

See §483.10(b)(8), F156 with respect to the advance directive requirement.

F156



§483.10(b)(1) -- The 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. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing;

Intent §483.10(b)(1)

This requirement is intended to assure that each resident know his or her rights and responsibilities and that the facility communicates this information prior to or upon admission, as appropriate during the resident's stay, and when the facility's rules change.

Interpretive Guidelines §483.10(b)(1)

"In a language that the resident understands" is defined as communication of information concerning rights and responsibilities that is clear and understandable to each resident, to the extent possible considering impediments which may be created by the resident's

health and mental status. If the resident's knowledge of English or the predominant language of the facility is inadequate for comprehension, a means to communicate the information concerning rights and responsibilities in a language familiar to the resident must be available and implemented. For foreign languages commonly encountered in the facility locale, the facility should have written translations of its statements of rights and responsibilities, and should make the services of an interpreter available. In the case of less commonly encountered foreign languages, however, a representative of the resident may sign that he or she has explained the statement of rights to the resident prior to his/her acknowledgement of receipt. For hearing impaired residents who communicate by signing, the facility is expected to provide an interpreter. Large print texts of the facility's statement of resident rights and responsibilities should also be available.

"Both orally and in writing" means if a resident can read and understand written materials without assistance, an oral summary, along with the written document, is acceptable.

Any time State or Federal laws relating to resident rights or facility rules change during the resident's stay in the facility, he/she must promptly be informed of these changes.

"All rules and regulations" relates to facility policies governing resident conduct. A facility cannot reasonably expect a resident to abide by rules he or she has never been told about. Whatever rules the facility has formalized, and by which it expects residents to abide, should be included in the statement of rights and responsibilities.

§483.10(b)(5) -- The facility must--

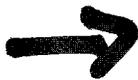


(i) Inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of--

(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;

(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and

(ii) Inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.



§483.10(b)(6) -- The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

Interpretive Guidelines §483.10(b)(5) and (6)

Residents should be told in advance when changes will occur in their bills. Providers must fully inform the resident of services and related changes.

“Periodically” means that whenever changes are being introduced that will affect the residents liability and whenever there are changes in services.

A Medicare beneficiary who requires services upon admission that are not covered under Medicare may be required to submit a deposit provided the notice provisions of §483.10(b)(6), if applicable, are met.

Procedures §483.10(b)(5) and (6)

See §483.10(c)(8) for those items and services that must be included in payment under skilled nursing and nursing facility benefits.

§483.10(b)(7) -- The facility must furnish a written description of legal rights which includes--

(i) A description of the manner of protecting personal funds, under paragraph (c) of this section;

(ii) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple’s non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse’s medical care in his or her process of spending down to Medicaid eligibility levels;



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



(iv) A statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

Interpretive Guidelines §483.10(b)(7)

“The protection and advocacy network” refers to the system established to protect and advocate the rights of individuals with developmental disabilities specified in the

Developmental Disabilities Assistance and Bill of Rights Act, and the protection and advocacy system established under the Protection and Advocacy for Mentally Ill Individuals Act.

Procedures §483.10(b)(7)

At the Entrance Conference, request a copy of the written information that is provided to residents regarding their rights and review it to determine if it addresses the specified requirements. Additional requirements that address the implementation of these rights are cross-referenced below.

§483.10(b)(8) -- The facility must comply with the requirements specified in subpart I of part 489 of this chapter relating to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law

Interpretive Guidelines §483.10(b)(8)

This provision applies to residents admitted on or after December 1, 1991. 42 CFR 489.102 specifies that at the time of admission of an adult resident, the facility must:

- Provide written information concerning his/her rights under State law (whether or not statutory or recognized by the courts of the State) to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives;
- Document in the resident's medical record whether or not the individual has executed an advance directive;
- Not condition the provision of care or discriminate against an individual based on whether or not the individual has executed an advance directive;
- Ensure compliance with requirements of State law regarding advance directives;
- Provide for educating staff regarding the facility's policies and procedures on advance directives; and
- Provide for community education regarding the right under State law (whether or not recognized by the courts of the State) to formulate an advance directive and the facility's written policies and procedures regarding the implementation of these rights, including any limitations the facility may have with respect to implementing this right on the basis of conscience.

The facility is not required to provide care that conflicts with an advance directive. In addition, the facility is not required to implement an advance directive if, as a matter of conscience, the provider cannot implement an advance directive and State law allows the provider to conscientiously object. (See §483.10(b)(4), F155.)

The sum total of the community education efforts must include a summary of the State law, the rights of residents to formulate advance directives, and the facility's implementation policies regarding advance directives. Video and audio tapes may be used in conducting the community education effort. Individual education programs do not have to address all the requirements if it would be inappropriate for a particular audience.

Procedures §483.10(b)(8)

During Resident Review, review the records of two selected sampled residents admitted on or after December 1, 1991, for facility compliance with advance directive notice requirements.

- Determine to what extent the facility educates its staff regarding advance directives.
- Determine to what extent the facility provides education for the community regarding one's rights under State law to formulate advance directives.

§483.10(b)(9) -- The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

Interpretive Guidelines §483.10(b)(9)

"Physician responsible for his or her care" is defined as the attending or primary physician or clinic, whichever is responsible for managing the resident's medical care, and excludes other physicians whom the resident may see from time to time. When a resident has selected an attending physician, it is appropriate for the facility to confirm that choice when complying with this requirement. When a resident has no attending physician, it is appropriate for the facility to assist residents to obtain one in consultation with the resident and subject to the resident's right to choose. (See §483.10(d)(1), F163.)

If a facility uses the services of a clinic or similar arrangement, it may be sufficient for residents to have the name and contact information for the primary physician and/or a central number for the clinic itself.

§483.10(b)(10) -- The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

Interpretive Guidelines §483.10(b)(10)

To fulfill this requirement, the facility may use written materials issued by the State Medicaid agency and the Federal government relating to these benefits. Facilities may fulfill their obligation to orally inform residents or applicants for admission about how to apply for Medicaid or Medicare by assisting them in contacting the local Social Security Office or the local unit of the State Medicaid agency. Nursing facilities are not responsible for orally providing detailed information about Medicare and Medicaid eligibility rules.

“Refunds for previous payments” refers to refunds due as a result of Medicaid and Medicare payments when eligibility has been determined retroactively.

As part of determining Medicaid eligibility, at the time of admission, a married couple has the right to request and have the appropriate State agency assess the couple’s resources.

F157

§483.10(b)(11) -- Notification of changes.

(i) A facility must immediately inform the resident; consult with the resident’s physician; and if known, notify the resident’s legal representative or an interested family member when there is--

(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;

(B) A significant change in the resident’s physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);

(C) A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or

(D) A decision to transfer or discharge the resident from the facility as specified in §483.12(a).

(ii) The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is--

**(A) A change in room or roommate assignment as specified in §483.15(e)(2);
or**

(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

(iii) The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

Interpretive Guidelines §483.10(b)(11)

For purposes of §483.10(b)(11)(i)(B), life-threatening conditions are such things as a heart attack or stroke. Clinical complications are such things as development of a stage II pressure sore, onset or recurrent periods of delirium, recurrent urinary tract infection, or onset of depression. A need to alter treatment "significantly" means a need to stop a form of treatment because of adverse consequences (e.g., an adverse drug reaction), or commence a new form of treatment to deal with a problem (e.g., the use of any medical procedure, or therapy that has not been used on that resident before).

In the case of a competent individual, the facility must still contact the resident's physician and notify interested family members, if known. That is, a family that wishes to be informed would designate a member to receive calls. Even when a resident is mentally competent, such a designated family member should be notified of significant changes in the resident's health status because the resident may not be able to notify them personally, especially in the case of sudden illness or accident.

The requirements at §483.10(b)(1) require the facility to inform the resident of his/her rights upon admission and during the resident's stay. This includes the resident's right to privacy (§483.10(e), F164). If, after being informed of the right to privacy, a resident specifies that he/she wishes to exercise this right and not notify family members in the event of a significant change as specified at this requirement, the facility should respect this request, which would obviate the need to notify the resident's interested family member or legal representative, if known. If a resident specifies that he/she does not wish to exercise the right to privacy, then the facility is required to comply with the notice of change requirements.

In the case of a resident who is incapable of making decisions, the representative would make any decisions that have to be made, but the resident should still be told what is happening to him or her.

In the case of the death of a resident, the resident's physician is to be notified immediately in accordance with State law.

The failure to provide notice of room changes could result in an avoidable decline in physical, mental, or psychosocial well-being.

§483.10(c) Protection of Resident Funds

F158

§483.10(c)(1) Protection of Resident Funds

The resident has the right to manage his or her financial affairs, and the facility may not require residents to deposit their personal funds with the facility.

F159

§483.10(c)(2) Management of Personal Funds

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 specified in paragraphs (c)(3)-(8) of this section.

§483.10(c)(3) Deposit of Funds

(i) Funds in excess of \$50. The facility must deposit any residents' personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)

(ii) Funds less than \$50. The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.

NOTE: The Social Security Amendments of 1994 amended §1819(c)(6)(B)(i) to raise the limit from \$50.00 to \$100.00 for the minimum amount of resident funds that facilities must entrust to an interest bearing account. This increase applies only to Medicare SNF residents. While a facility may continue to follow a minimum of \$50.00, the regulations do not require it.

Interpretive Guidelines §483.10(c)(1) through (3)

This requirement is intended to assure that residents who have authorized the facility in writing to manage any personal funds have ready and reasonable access to those funds. If residents choose to have the facility manage their funds, the facility may not refuse to handle these funds, but is not responsible for knowing about assets not on deposit with it.

If there is information considered too confidential to place in the record used by all staff, such as the family's financial assets or sensitive medical data, it may be retained in a secure place in the facility, such as a locked cabinet in the administrator's office. The record should show the location of this confidential information.

§483.10(f) Grievances

A resident has the right to--

F165

A resident has the right to –

§483.10(f)(1) --Voice grievances without discrimination or reprisal. Such grievances include those with respect to treatment which has been furnished as well as that which has not been furnished; and

(SEE TAG 166 FOR GUIDANCE)

F166

A resident has the right to--

§483.10(f)(2) -- Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

Intent §483.10(f)

The intent of the regulation is to support each resident's right to voice grievances (e.g., those about treatment, care, management of funds, lost clothing, or violation of rights) and to assure that after receiving a complaint/grievance, the facility actively seeks a resolution and keeps the resident appropriately apprised of its progress toward resolution

Interpretive Guidelines §483.10(f)

"Voice grievances" is not limited to a formal, written grievance process but may include a resident's verbalized complaint to facility staff.

"Prompt efforts...to resolve" include facility acknowledgment of complaint/grievances and actively working toward resolution of that complaint/grievance.

If residents' responses indicate problems in voicing grievances and getting grievances resolved, determine how the facility deals with and makes prompt efforts to resolve resident complaints and grievances.

- With permission, review resident council minutes.
- Interview staff about how grievances are handled.
- Interview staff about communication (to resident) of progress toward resolution of complaint/grievance.

If problems are identified, also investigate compliance with §483.10(b)(7)(iii).

§483.10(g) Examination of Survey Results

F167

A resident has the right to--

- (1) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination in a place readily accessible to residents and must post a notice of their availability; and**

SEE GUIDANCE UNDER TAG 168

F168

A resident has the right to:

§483.10(g)(2) -- Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.

Interpretive Guidelines §483.10(g)(1)-(2)

“Results of the most recent survey” means the Statement of Deficiencies (Form CMS-2567) and the Statement of Isolated Deficiencies generated by the most recent standard survey and any subsequent extended surveys, and any deficiencies resulting from any subsequent complaint investigation(s).

“Made available for examination” means that survey results and approved plan of correction, if applicable, are available in a readable form, such as a binder, large print, or are provided with a magnifying glass, have not been altered by the facility unless authorized by the State agency, and are available to residents without having to ask a staff person.

the request of a resident (for example, when a privately paying Medicare beneficiary believes that admission to a bed in a Medicare-participating distinct part of the institution may result in Medicare payment).

See Guidelines, [§483.12](#) for further discussion regarding transfers.

For transfers of residents between Medicare or Medicaid approved distinct parts:

- Is there a documented medical reason for the transfer?
- Was the resident transferred because of a change in payment source?
- If a Medicare or Medicaid resident is notified that he/she is no longer eligible, does the facility transfer the resident? Did the facility give the resident the opportunity to refuse the transfer? How? What happened?
- Ask the local ombudsman about facility compliance with transfer requirements. See also [§483.12](#), Criteria for Transfer.



§483.12 Admission, Transfer, and Discharge Rights

§483.12(a) 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.

Guidelines §483.12

This requirement applies to transfers or discharges that are initiated by the facility, not by the resident. Whether or not a resident agrees to the facility's decision, these requirements apply whenever a facility initiates the transfer or discharge. "Transfer" is moving the resident from the facility to another legally responsible institutional setting, while "discharge" is moving the resident to a non-institutional setting when the releasing facility ceases to be responsible for the resident's care.

If a resident is living in an institution participating in both Medicare and Medicaid (SNF/NF) under separate provider agreements, a move from either the SNF or NF would constitute a transfer.

Transfer and discharge provisions significantly restrict a facility's ability to transfer or discharge a resident once that resident has been admitted to the facility. The facility may not transfer or discharge the resident unless:

1. The transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility;
2. 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;
3. The safety of individuals in the facility is endangered;
4. The health of individuals in the facility would otherwise be endangered;
5. The resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility; or
6. The facility ceases to operate.

To demonstrate that any of the events specified in 1 - 5 have occurred, the law requires documentation in the resident's clinical record. To demonstrate situations 1 and 2, the **resident's** physician must provide the documentation. In situation 4, the documentation must be provided by **any** physician. (See §483.12(a)(2).)

Moreover, before the transfer or discharge occurs, the law requires that the facility notify the resident and, if known, the family member, surrogate, or representative of the transfer and the reasons for the transfer, and record the reasons in the clinical record. The facility's notice must include an explanation of the right to appeal the transfer to the State as well as the name, address, and phone number of the State long-term care ombudsman. In the case of a developmentally disabled individual, the notice must include the name, address and phone number of the agency responsible for advocating for the developmentally disabled, and in the case of a mentally ill individual, the name, address and phone number of the agency responsible for advocating for mentally ill individuals. (See §483.12(a)(3) and (5).)

Generally, this notice must be provided at least 30 days prior to the transfer. Exceptions to the 30-day requirement apply when the transfer is effected because of:

- Endangerment to the health or safety of others in the facility;
- When a resident's health has improved to allow a more immediate transfer or discharge;
- When a resident's urgent medical needs require more immediate transfer; and

- When a resident has not resided in the facility for 30 days.

In these cases, the notice must be provided as soon as practicable before the discharge. (See §483.12(a)(4).)

Finally, the facility is required to provide sufficient preparation and orientation to residents to ensure safe and orderly discharge from the facility. (See §483.12(a)(6).)

Under Medicaid, a participating facility is also required to provide notice to its residents of the facility's bed-hold policies and readmission policies prior to transfer of a resident for hospitalization or therapeutic leave. Upon such transfer, the facility must provide written notice to the resident and an immediate family member, surrogate or representative of the duration of any bed-hold. With respect to readmission in a Medicaid participating facility, the facility must develop policies that permit residents eligible for Medicaid, who were transferred for hospitalization or therapeutic leave, and whose absence exceeds the bed-hold period as defined by the State plan, to return to the facility in the first available bed. (See §483.12(b).)

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. 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.

§483.10(o), Tag F177, addresses the right of residents to refuse certain transfers within an institution on the basis of payment status.

F201



§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 for the resident's welfare and the resident's needs 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.

SEE GUIDANCE UNDER TAG 202

F202

§483.12(a)(3) Documentation

When the facility transfers or discharges a resident under any of the 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) of this section; and

(ii) A physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.

Interpretive Guidelines §483.12(a)(2) and (3)

If transfer is due to a significant change in the resident's condition, but not an emergency requiring an immediate transfer, then prior to any action, the facility must conduct the appropriate assessment to determine if a new care plan would allow the facility to meet the resident's needs. (See §483.20(b)(4)(iv), F274, for information concerning assessment upon significant change.)

Conversion from a private pay rate to payment at the Medicaid rate does not constitute non-payment.

Refusal of treatment would not constitute grounds for transfer, unless the facility is unable to meet the needs of the resident or protect the health and safety of others.

Documentation of the transfer/discharge may be completed by a physician extender unless prohibited by State law or facility policy.

Procedures §483.12(a)(2) and (3)

During closed record review, determine the reasons for transfer/discharge.

- Do records document accurate assessments and attempts through care planning to address resident's needs through multi-disciplinary interventions, accommodation of individual needs and attention to the resident's customary routines?
- Did the resident's physician document the record if:
 - The resident was transferred/discharged for the sake of the resident's welfare and the resident's needs could not be met in the facility (e.g., a resident develops an acute condition requiring hospitalization)? or
 - The resident's health improved to the extent that the transferred/discharged resident no longer needed the services of the facility.
- Did a physician document the record if residents were transferred because the health of individuals in the facility is endangered?
- Do the records of residents transferred/discharged due to safety reasons reflect the process by which the facility concluded that in each instance transfer or discharge was necessary? Did the survey team observe residents with similar safety concerns in the facility? If so, determine differences between these residents and those who were transferred or discharged.
- Look for changes in source of payment coinciding with transfer. If you find such transfer, determine if the transfers were triggered by one of the criteria specified in §483.12(a)(2).
- Ask the ombudsman if there were any complaints regarding transfer and/or discharge. If there were, what was the result of the ombudsman's investigation?
- If the entity to which the resident was discharged is another long term care facility, evaluate the extent to which the discharge summary and the resident's physician justify why the facility could not meet the needs of this resident.

F203

→ §483.12(a)(4) Notice Before Transfer

Before a facility transfers or discharges a resident, the facility must--

(i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.

(ii) Record the reasons in the resident's clinical record; and

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

§483.12(a)(5) Timing of the notice.

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

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

(A) The safety of 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;

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

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

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

§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 transfer or discharge;

(ii) The effective date of transfer or discharge;

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

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

(v) The name, address and telephone number of the State long term care ombudsman;

(vi) For nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and

advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and

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

Procedures §483.12(a)(4)-(6)

If the team determines that there are concerns about the facility's transfer and discharge actions, during closed record review, look at notices to determine if the notice requirements are met, including:

- Advance notice (either 30 days or, as soon as practicable, depending on the reason for transfer/discharge);
- Reason for transfer/discharge;
- The effective date of the transfer or discharge;
- The location to which the resident was transferred or discharged;
- Right of appeal;
- How to notify the ombudsman (name, address, and telephone number); and
- How to notify the appropriate protection and advocacy agency for residents with mental illness or mental retardation (mailing address and telephone numbers).
- Determine whether the facility notified a family member or legal representative of the proposed transfer or discharge.

F204

§483.12(a)(7) Orientation for Transfer or Discharge

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

Interpretive Guidelines §483.12(a)(7)

“Sufficient preparation” means the facility informs the resident where he or she is going and takes steps under its control to assure safe transportation. The facility should