

**MODULE 3**  
**THE LONG TERM CARE SETTING**

I. Types of Homes and Levels of Care

- A. Skilled Nursing Facilities
- B. Nursing Facilities
- C. Board and Care Facilities
- D. Assisted Living Facilities

II. Staffing and Departments of Nursing Homes

- A. Administration
- B. Nursing Services
- C. Dietary Department
- D. Activities Department
- E. Social Services
- F. Housekeeping and Laundry
- G. Medical Staff

III. Programs

IV. Long Term Care Residents

- A. Entry Into Long Term Care
- B. Population in Long Term Care Facilities
- C. Adjustment to Institutionalization

V. Long Term Care Reimbursement

- A. Medicaid
- B. Medicare
- C. Veterans Administration
- D. Long Term Care Insurance

VI. Regulations Governing Long Term Care Facilities

- A. Federal Regulation/Certification
- B. State Regulation/Licensure
- C. Nursing Home Pre-Admission Screening and Annual Resident Review
- D. Enforcement in Long Term Care Facilities

## **I. Types Of Homes And Levels Of Care**

### **A. Skilled Nursing Facilities (SNF)**

A Skilled Nursing Facility is a nursing home that provides 24-hour a day skilled nursing care and related services, or rehabilitative services for injured, disabled, or sick persons. Medicare pays for residents with Medicare insurance for short term care only in a SNF certified facility. Medicaid will pay for long term nursing home care for eligible residents in a certified Nursing Facility (NF).

SNF care provides:

- Supportive care to patients whose primary need is for skilled nursing care on an extended basis.
- 24-hour patient care, including medical, nursing, dietary, pharmaceutical services and an activity program.
- Rehabilitation services, such as gait training, and bowel and bladder training.
- Higher patient/staff ratio.
- Administration of potent and dangerous injectable medications and intravenous medications and solutions on a regular basis.

Examples of conditions skilled care residents might have are cancer, fractures, and cardio-vascular accidents.

### **B. Nursing Facilities (NF)**

A Nursing Facility (NF) is a nursing home licensed under state law that provides health-related care and services to individuals who do not require hospital or SNF care, but whose mental or physical condition requires services (a) above the level of residential or board and care, that (b) can be provided only by an institution. Medicaid pays for residents at the NF level of care. Nursing facilities are what people generally call nursing homes – they provide long-term care for residents who with chronic conditions.

NF care provides:

- In-patient care for residents who need nursing supervision and supportive care but who do not require continuous nursing care or rehabilitation.
- Personal care, such as proper positioning in bed or chair, bed baths, treatment of skin irritations, assistance and training in self- care for feeding, grooming, and toilet activities.
- Lower resident/staff ratio.

Residents will have chronic illnesses, including but not primarily mental illnesses, that are stabilized, but require medication and a range of services to prevent further deterioration.

The District has 20 licensed nursing homes licensed with about 3100 nursing home beds. The average cost for a private pay resident is \$245 per day, over \$7000 per month. Basic information about these nursing homes follows:

1. **Capitol View Sub-Acute Howard University Hospital** (202) 865-6228  
 (202) 865-7820 fax  
 6<sup>th</sup> Floor west  
 2041 Georgia Avenue, NW  
 Washington D.C. 20060  
 Administrator: Nora Wellington  
 Ownership: Non Profit - Corporation  
 Services: 28 beds  
 Fees: Medicare, Medicaid
  
2. **Carroll Manor Nursing and Rehabilitation Center at Providence Hospital** (202) 269-7100  
 1155 Varnum Street, NE . (202) 865-7820 fax  
 Washington D.C. 20017 Web Site – Provhosp.org  
 Administrator: Eileen Mulaney  
 Ownership: Non Profit - Corporation  
 Services: 230 Medicaid, 20 Medicare  
 Fees: Medicare, Medicaid
  
3. **Grant Park Care Center** (202) 399-7504  
 5000 Nannie Helen Burroughs Ave. NE (202) 396-8510 fax  
 Washington, DC 20009 EMail:centinniahc@grantpark14  
 Administrator: Calanthia Green  
 Executive Director: Darlene Ruffin-Alexander  
 Ownership: Profit - Partnership  
 Services: 296 beds  
 Fees: Medicare, Medicaid certified
  
4. **Hadley Memorial Hospital SNF** (202) 574-5700  
 4601 Martin Luther King Jr. Ave. SW (202) 373-5906 fax  
 Washington D.C. 20032  
 Administrator: Janine Finck-Boyle  
 Ownership: Profit - Corporation  
 Services: 103 beds  
 Fees: Medicare, Medicaid
  
5. **Health Care Institute** (202) 279-5825  
 1380 Southern Ave. SE (202) 563-9199 fax  
 Washington DC 20032  
 Acting Administrator: Linda Robinson  
 Ownership: Non Profit - Corporation  
 Services: 183 beds  
 Fees: Medicare, Medicaid

6. **Ingleside at Rock Creek.** (202) 363-8310  
 3050 Military Rd. NW (202)363-4215 fax  
 Washington DC 20015 [www.urcdc.org](http://www.urcdc.org) web site  
 Administrator: Peter Heck  
 Admission coordinator: Samora St. Firmin  
 Ownership: Non-profit, church related  
 Services: 73 beds  
 Fees: (Sliding fee scale) Medicaid & Medicare certified
7. **J.B. Johnson Nursing Center** (202) 535-1100  
 901 - 1st St. NW (202) 408-8098 fax  
 Washington DC 20001  
 Acting Administrator: Rosalyn Wright  
 Ownership: Non-Profit, D.C. government  
 Services: 208 beds  
 Fees: Medicaid, Medicare
8. **Knollwood** (202) 541-0400 x 150  
 6200 Oregon Ave. NW (202) 541-0338 fax  
 Washington DC 20015  
 Administrator: Barbara D'Agostino  
 Ownership: Non profit - Corporation  
 Services: 50 beds  
 Fees: Medicare, Medicaid  
 Other: Must have served at least 20 years in the U.S. Army or  
 be a family member of a career officer
9. **Lisner Louise Dickens and Hurt Home** (202) 966-6667  
 5425 Western Ave. NW (202) 541-0338 fax  
 Washington DC 20015 E-Mail: lworem@lldhhome.org  
 Administrator: Ward Orem  
 Ownership: Non Profit - Corporation  
 Services: 60 beds; 51 community residence facility beds  
 Fees: Medicare and Medicaid
10. **Little Sisters of the Poor** (202) 269-1831  
 4200 Harewood Rd. NE (202) 269-1134 fax  
 Washington DC 20017 E-mail:mswashlsp@earthlink.net  
 Administrator: Mother Cecilia Mary  
 Ownership: Non-Profit, church related  
 Services: 20 beds; 20 community residence facility beds;  
 24 independent apartments; 35 Residential  
 Fees: Medicaid  
 Other: Only admit people over 60

11. **MedLink Nursing Center** (202) 675-0400  
 700 Constitution Avenue, NE (202) 675-0411 fax  
 Washington, DC 20002  
 Administrator: Leonard Smith  
 Ownership: Profit  
 Services: 145 beds  
 Fees: Medicare, Medicaid
12. **Methodist Home** (202) 966-7623  
 4901 Connecticut Ave. NW (202) 362-6917 fax  
 Washington DC 20008 Website: methodisthomeofdc.org  
 Administrator: Sandy Douglass  
 Ownership: Non-profit, church-related  
 Services: 120 beds  
 Fees: Medicaid, Medicare certified
13. **Northwest Health Care Center** (202) 362-5500  
 3333 Wisconsin Avenue N.W. (202)537-5833 fax  
 Washington D.C. 20016 Website: www.beverly.com  
 Administrator: Joyce Jones  
 Ownership: Profit - Corporation  
 Services: 355 beds  
 Fees: Medicare, Medicaid certified
14. **Rock Creek Manor** (202) 785-2577  
 2131 O St. NW (202) 331-0875 fax  
 Washington DC 20037  
 Administrator: Dr. Joseph Umoren  
 Ownership: Profit - Corporation  
 Services: 180 nursing facility beds  
 Fees: Medicaid, Medicare certified
15. **Sibley Memorial Hospital Renaissance Skilled Nursing Unit** (202) 243-5170  
 5255 Loughboro Rd. N.W. (202) 537-4067 fax  
 Washington D.C. 20016 Website: www.sibley.org  
 Administrator: Barry Eisenberg  
 Ownership: Non Profit - Corporation  
 Services: 40 beds  
 Fees: Medicare, Medicaid certified
16. **Stoddard Baptist Home** (202) 328-7400  
 1818 Newton St. NW (202)328-0421 fax  
 Washington DC 20010 Website: stoddardbaptisthome.org  
 Administrator: Steve Nash

Ownership: Profit, church-related  
Services: 164 beds  
Fees: Medicare, Medicaid certified

17. **Thomas House** (202) 628-3844  
1330 Massachusetts Ave. NW (202) 638-0649 fax  
Washington DC 20005  
Administrator: Annette Price  
Ownership: Non-profit, church-related  
Services: 53 beds, 5 skilled beds, 150 independent apartments  
Fees: Medicare and Medicaid
18. **Washington Center for Aging Services** (202) 541-6200  
2601 - 18th St. NE (202)541-6191 fax  
Washington DC 20018  
Administrator: Rose Marie Gilliam  
Ownership: Non-profit, D.C. government  
Services: 263 beds  
Fees: Medicare, Medicaid certified  
Other: Only admit people over 60 years
19. **Washington Home** (202) 966-3720  
3720 Upton St. NW (202) 895-0295 fax  
Washington DC 20016 Website: [washingtonhome.org](http://washingtonhome.org)  
Administrator: Adam Utan  
Ownership: Non Profit - Corporation  
Services: 189 beds; 9 hospice beds  
Fees: Medicare, Medicaid certified
20. **Washington Nursing Facility** (202) 889-3600  
2425 - 25th St. SE (202) 678-6579 fax  
Washington DC 20020  
Administrator: Gail Jernigan  
Ownership: Profit - Partnership  
Services: 340 beds  
Fees: Medicare, Medicaid

### **C. Board And Care Facilities**

The 1981 Amendments to the federal Older Americans Act extended the responsibility of the Ombudsman Program to include advocacy on behalf of residents of board and care homes.

Board and care homes in the District of Columbia are called Community Residence Facilities, or CRFs. Ombudsman Program staff visit CRFs and investigate complaints concerning residents who live in them.

Community Residence Facilities are generally run like “Mom and Pop” rooming houses and are usually created by using bedrooms in existing houses in residential neighborhoods. Often it is hard to tell the difference between a CRF and a family residence by looking at the exterior of the building.

There are about 174 licensed CRFs in the District of Columbia with approximately 1200 beds. CRFs must be licensed to operate; however, there are some unlicensed homes that continue to operate.

The residents of CRFs are often isolated and in many cases more vulnerable than nursing home residents. CRFs are not health care facilities, and, compared to a nursing home, provide a less restrictive environment.

A CRF is defined in D.C. regulations as a facility providing safe, hygienic sheltered living for one or more individuals aged 18 or older, not related by blood or marriage to the residence director, who are ambulatory and able to perform the activities of daily living with minimal assistance. The definition includes facilities which provide a sheltered living arrangement for persons who desire or require supervision or assistance within a protective environment because of physical, mental or social circumstances.

There are no federal regulations governing board and care homes. The D.C. government inspects these facilities annually and has local regulations that govern the care and services provided.

CRFs cost from \$785 to \$3,200 a month. The smallest licensed CRF in D.C. has 3 residents and the largest has 150 residents. The average size is from 5-8 residents.

Under federal and D.C. law, the Ombudsman Program has access to all CRFs and is responsible for investigating complaints about CRFs and advocating on behalf of CRF residents.

### **D. Assisted Living Facilities (ALFs)**

The Ombudsman Program also advocates on behalf of residents of board and care homes. Ombudsman Program staff visit ALFs and investigate complaints concerning residents who live in them.

Assisted Living Facilities are typically for profit apartment style residences that provide one or more meals, minimal assistance with activities of daily living, and social and recreational activities. They are primarily private pay facilities in which residents pay monthly rent for their apartment and contract for additional specific services based on their level of need.

There are 13 ALFs in the District of Columbia with approximately 900 beds. Currently, there are no federal or District regulations governing ALFs, so they are not licensed as ALFs or monitored by the D.C. Department of Health. However, a few ALFs are licensed as CRFs, and some are connected to D.C. nursing homes (i.e., Lisner Louise, Thomas House, Knollwood, Methodist Home, and Ingleside).

ALFs are not health care facilities and provide a less restrictive than a nursing home or CRF. Therefore, the residents of ALFs are generally healthier and more independent than nursing home residents. The majority of the District's ALFs also offer a more upscale environment and amenities than a nursing home or CRF.

ALFs cost from an average of \$3,500 to \$5,500 a month, depending on services contracted for by the resident. The average number of residents in D.C. ALFs is 60.

Under federal and D.C. law, the Ombudsman Program has access to all ALFs and is responsible for investigating complaints about ALFs and advocating on behalf of ALF residents.

## **II. Staff and Departments of Nursing Homes**

The staff in a long term care facility are assigned to various departments, e.g., nursing, housekeeping, dietary, etc. Each department is responsible for contributing to the overall functioning of the facility. The size and composition of departments of each facility are contingent upon the facility's total size and the level of care provided. Although there may be differences between nursing homes, the following paragraphs describe the structure of a "typical" nursing home and examples of departmental responsibilities and staff.

### **A. Administration**

The administrative unit of a nursing home usually includes the nursing home administrator, medical director, administrative support staff, business office staff, and admissions staff.

The Nursing Home Administrator is responsible for the overall fiscal, legal, medical, and social management and operation of the facility. This individual is ultimately responsible for all nursing home activities.

The Medical Director is a physician who formulates and directs overall resident care policies and supervises medical care in the nursing home.

The Business Office is responsible for billing and overseeing residents' accounts.

The Admissions Office is responsible for overseeing and processing admissions and discharges, assisting with information and applications for Medicaid and Medicare benefits, and providing information regarding contracts, policies, and procedures.

### **B. Nursing Services**

The nursing services section includes Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Certified Nursing Assistants (CNAs), also referred to as Nurse Aides. These are the people who provide direct care to the residents.

Nursing services are overseen by a Director of Nursing (DON) — a full-time registered nurse (RN) who oversees the entire nursing staff, including nursing supervisors, licensed practical nurses, and nurse aides. The DON is responsible for the quality and safety of patient care.

Nursing Supervisors (also called charge nurses) are responsible for nursing (resident) care on a floor, or in an area or section, or in the nursing home in general during a particular shift. Nursing supervisors may be RNs or LPNs.

Licensed Practical Nurses (LPNs) are individuals who have completed one year of vocational training in nursing. They may be in charge of nursing in the absence of an RN. LPNs often administer medications and perform treatments.

Certified Nursing Assistants (CNAs) or Nurse Aide supply 80-90% of the “hands-on” patient care given in nursing homes. Within four months of employment by a nursing facility or skilled nursing facility, nurse aides are required to complete a training and competency evaluation program approved by the state, and be competent to provide nursing and nursing related services.

The DC Nursing Facility Licensure Rules require that at least one RN be on duty 24 hours per day, 7 days per week.

### **C. Dietary Department**

The dietary program is responsible for planning and preparing the food served in a nursing home in accordance with state licensure regulations and federal certification requirements. Some nursing homes have a menu cycle, such as a four-week cycle or a seasonal cycle. Special diets must be ordered by a physician. Any food brought to a resident by friends or family should be checked with the nurse in charge to assure that it will not interfere with the effectiveness of a prescribed diet.

The dietary staff should include:

Dietician — expert in planning menus, diets and dietary procedures. The dietician is responsible for setting up special diets, as well as maintaining proper nutritional levels for residents.

Food Services Supervisor — responsible for the daily preparation of foods, special diets, etc. He/she follows the menus developed by the dietician and is responsible for ensuring that regulations for food safety and environmental sanitation are followed.

### **D. Activities Department**

An activities program is a requirement for certification of nursing facilities (NF) and skilled nursing facilities (SNF). Activities planned should be appropriate to the needs and interests of the residents and should enhance the quality of life.

In facilities of 60 or more licensed beds, the activities program shall be directed by a Recreational Therapist (also called Activities Coordinator or Activities Director) or activities staffperson, certified or recognized by an accredited body, who is responsible for developing, scheduling, and conducting programs to meet the social and recreational needs of the residents.

### **E. Social Services**

Social Services departments are responsible for identifying the medically- related and emotional needs of the patient. An assessment of each resident's needs should be found in his/her record and needed services should be incorporated into the care plan. OBRA 1987 requires every nursing facility with more than 120 beds to employ a full-time professionally licensed social worker.

### **F. Housekeeping And Laundry**

Members of the housekeeping staff are usually responsible for basic housekeeping chores such as sweeping floors, dusting, emptying waste cans, and cleaning furnishings.

Every nursing home has laundry facilities and is responsible for providing clean bed linens and towels. The home is also equipped to launder residents' clothing.

### **G. Medical Staff**

Medical staff are responsible for attending to the physical needs of the residents. Nursing is the most obvious medical department. Other health care personnel may include:

Attending Physicians, who are directly responsible for the care of resident. Each resident must either choose his/her own physician or have one assigned by the nursing home to supervise his/her care.

Podiatrist, who specializes in the diagnosis and treatment of diseases, defects and injuries of the foot.

Dermatologist, who specializes in the diagnosis and treatment of diseases, defects, and injuries of the skin.

Ophthalmologist, who specializes in the diagnosis and treatment of diseases, defects and injuries of the eye.

Physical Therapist (PT), who is trained in restoring the function of muscles in arms, legs, backs, hands, feet, etc., through movement, exercises, or treatment. Sometimes physical therapy assistants carry out the plans of the therapist.

Occupational Therapist (OT), who is trained to conduct therapy to restore the fine muscles of the hands and arms.

It is important that the ombudsman request to see the organizational chart of the nursing home in order to understand the administrative lines of authority, responsibility, and supervision and to identify the appropriate persons when information from staff at a particular institution is required.

## **III. Programs**

Just as staffing patterns are different, programs offered in a nursing home will vary from place to place depending upon the type of residents served, availability of personnel, and the amount of income that the home can generate. The locale of the facility also influences the type of personnel available in a given community. However, basic programs that should be offered in every nursing home include the following:

Reality Orientation — Round-the-clock efforts to orient confused persons to who they are, time, place, and names of people and things around them.

Restorative Services — Services to maintain residents' good body alignment and proper positioning of bedridden residents; turning and repositioning bed-bound and chair-bound residents; encouraging residents to participate in activities and perform activities of daily living; implementing strategies to improve problems with behavior and/or confusion.

Continence Training -- Program to identify and provide bowel and bladder training to decrease incontinence and unnecessary use of catheters.

Recreational Activities — Activities to stimulate and entertain residents, including arts and crafts, music, movies, social gatherings, discussion groups, and outside events. While nursing home volunteers may perform many functions, they are most commonly active in these programs.

Exercise — Group or individual exercise programs to maintain or improve muscle function, increase circulation and enhance a sense of well-being.

Grief Therapy — Group discussions (usually led by a nurse therapist or social worker) designed to assist residents in expressing unresolved grief in order to release energies for more satisfying activities.

Residents' Council — A group formed by residents committed to expressing the needs and desires of residents to staff.

Family Council — A group formed by residents' family members who are committed to expressing the needs and desires of residents to staff.

For residents and family members, the Residents' Council and Family Council provide a tool to exercise some role in decision-making, an opportunity to ventilate feelings, an information forum, a vehicle for communicating to staff, and a sense of group support. For the staff, the councils provide a means for gathering resident and family input, a method of clarifying roles and responsibilities within the home, help in program policy planning, promotion of more orderly problem resolution in many instances, and greater awareness of resident problems by staff.

#### **IV. Long Term Care Residents**

How do individuals end up entering long term care settings? For the elderly, there is generally a gradual progression of losses, diminution of strengths, decreasing opportunities for meaningful and restorative personal and social experiences, and increased isolation. For younger individuals, disabling accidents and illnesses often result in loss of the ability to function independently. As self-sufficiency decreases for both the elderly and disabled, there is less opportunity for continued living in the community. Communities often don't have adequate services to replace and provide those which once came from the family and the neighborhood.

Generally, family members, a community agency, or a hospital (through the physician and social workers) determine that the older and/or disabled person can no longer adequately care for him/herself or be cared for in the community. When a long term care institution or

nursing home is chosen as an alternative, it is often the only option. Although the District offers a home and community based services option for those eligible for nursing facility services, there is a long waiting list for those services, a lack of reliable service providers, and a limit on the number of hours per day that services are available.

The transition that elderly and/or disabled persons (and their families) face when they move from a community setting to an institutional setting is a difficult one. Many of their physical and mental problems do not start with entry into the long term care setting, but must be dealt with there. Other problems facing the new resident arise because of the nature of the setting itself and how services are delivered within an institutional setting.

The decision to enter a nursing home usually is made after a crisis happens and there are pressures to choose a nursing home quickly. However, a nursing home should be selected only if the medical or rehabilitative services are really needed and cannot be obtained somewhere else. Many people enter nursing homes without thoroughly considering alternatives, such as staying at home and arranging for visiting nurses or home care aides or moving to a less restrictive housing arrangement, such as an assisted living facility, community residence facility, or apartment building for the elderly.

If it is determined that nursing home care is appropriate for an individual, the method of payment for care determines how to proceed with the placement process. The largest part of nursing home care in the District is paid for by Medicaid, which provides for long-term nursing facility care. In contrast, Medicare pays only for 20 days of skilled nursing or rehabilitative care and then pays only part of the cost for an additional 80 days maximum if skilled nursing or rehabilitative care is determined to be required. Medicare does not pay for long-term nursing facility care or for care in an assisted living or community residence facility. Private insurance pays for little, if any, nursing home care.

## **B. Populations in Long Term Care Facilities**

### **1. Elder Residents**

It is a stereotype that most elderly people live in nursing homes. The percent of people 65 years and over living in nursing homes in the U.S. declined from 5.1% in 1990 to 4.5 percent in 2000. This percentage declined for people 65-84 years, and especially for people 85 and over, 18.2 percent of whom lived in nursing homes in 2000, compared with 24.5 percent in 1990. In the District, persons 65 years and over comprised 12.3 percent of the population in 2000. In 2001, 4.1 percent of those 65 years and over lived in nursing homes, and 38.6 percent lived alone (the highest percentage in the country).

60.1% of District nursing home residents are 75 years and older.

27.7% of District nursing home residents are 60 to 75 years old.

12.1% of District nursing home residents are under 60 years old.

68.2% of District nursing home residents are women.

83.1% of District nursing home residents are African-American, 15.1% are Caucasian, 1% are Hispanic, and .4% are Asian.

Most nursing home residents have chronic or crippling disabilities and need help with the Activities of Daily Living (ADL), including assistance with bathing, dressing or eating.

Studies have shown that between 33 and 80% of nursing home residents also suffer from mental disorders. While most of these residents have some form of dementia, the percentage of residents who have reversible dementia that could be treated is unknown. In the District of Columbia, 17.5% of residents have Alzheimer's Disease, 43.3% have other types of dementia, and 13% have a history of mental illness.

It is likely that the nursing home population will continue to grow rapidly because by the year 2030, the older population is projected to more than double to about 70 million and the 85+ population is projected to increase from 4.2 to 8.9 million.

## 2. AIDS Population

The Centers for Disease Control and Prevention (CDC) estimate that 850,000 to 950,000 U.S. residents are living with HIV infection, one-quarter of whom are unaware of their infection. Approximately 40,000 new HIV infections occur each year in the United States, about 70 percent among men and 30 percent among women. Of these newly infected people, half are younger than 25 years of age.

The estimated number of AIDS diagnoses through 2002 in the United States is 886,575. Adult and adolescent AIDS cases total 877,275, with 718,002 cases in males and 159,271 cases in females. The estimated number of new adult/adolescent AIDS diagnoses in the United States was 43,225 in 1998; 41,134 in 1999; 42,239 in 2000; 41,227 in 2001; and 42,136 in 2002. As of the end of 2002, an estimated 384,906 people in the United States were living with AIDS.

Because the disease is more prevalent in younger people than in the traditional nursing home resident, the number of AIDS patients among the nursing home population is relatively small. For example, in D.C. only .5% of nursing home residents have HIV or AIDS. Nursing homes have also resisted the admission of AIDS patients because they tend to be younger males and do not fit the profile of the traditional resident -- an older female. Nevertheless, nursing homes are an appropriate setting for the care of AIDS patients who require long-term care nursing facility services, and it is a violation of the Americans with Disabilities Act and Section 504 of the Federal Rehabilitation Act to discriminate on the basis of disability. Since the AIDS virus is more prevalent among Blacks and Hispanics than among Caucasians, a nursing home's refusal to admit these populations may also violate Title VI of the Federal Civil Rights Act. These laws apply to all facilities that accept Medicare and/or Medicaid.

## 3. Mentally Retarded/Developmentally Disabled and Mentally Ill Populations

Persons diagnosed as Mentally Retarded/Developmentally Disabled (MR/DD) meet the following definitions:

**Developmental disabilities** are attributable to: (a) mental retardation, cerebral palsy, epilepsy or autism; or to (b) any other condition that results in impairment similar to

that caused by mental retardation and that requires services similar to those required by mentally retarded persons. Such disability must originate before an individual is 18 years old, be expected to continue indefinitely, and constitute a substantial handicap.

**Mental retardation** means significantly sub-average general intellectual functioning that exists concurrently with impairment in adaptive behavior and that originates before an individual is 18 years old.

The MR/DD population can reside in Community Residence Facilities. There are also MR/DD persons in nursing homes. Most of these residents are younger people, but some are older. Many were placed in nursing homes as the result of deinstitutionalization efforts that ended reliance on large warehouse-type institutions as the primary place for treatment. The MR/DD population came to reside in nursing homes for one of the following reasons:

- No community residence facility or other appropriate bed was available for the person in the community or close to their home;
- Individual had medical needs and needed care in a nursing home; or
- Individual was perceived as “old” and there was a presumed need for nursing home care.

Mental illness (MI) generally refers to psychoses like schizophrenia and affective disorders like bi-polar (manic-depression) personality. These are serious illnesses and need to be distinguished from situational depressions that result from grief or loss. Many mental illnesses are treatable and reversible, but some, like schizophrenia, can last a lifetime and need continued treatment. Some nursing homes have younger mentally ill residents for much the same reasons there may be MR/DD persons residing in the homes. In addition, older persons who require nursing home care may have or develop serious mental illnesses for which they need treatment.

Under federal Medicaid law, states are required to screen new admissions to prevent MR/DD and MI individuals from being placed in Medicaid-certified nursing homes if they do not require nursing home care and to ensure that they receive appropriate treatment in settings appropriate to their needs. This review system is called Pre-Admission Screening and Annual Resident Review (PASARR -- pronounced pass-are) and is administered and enforced by the Medicaid Agency in each state.

### **C. Adjustment to Institutionalization**

The move from one's home and community to a long term care setting is a major life event for both the resident and his/her family. Some individuals have great difficulty adjusting to life in an institution, which often requires many changes in lifestyle, including: set routines for meals; set times for getting up and going to bed; a decrease in contact with the community; more free time with structured activities available only at certain times; decreased privacy and independence; fewer opportunities for decision-making; loss of home, possessions, and links to the past; increased loneliness; and the need to adjust to staff and other residents. Normal reactions to these changes include anger, depression, grief, confusion, and withdrawal.

Although physical needs may be adequately met in an institutional setting, a resident's belief in him/herself as a worthwhile individual may be threatened. It is important, therefore, that residents' psychological, as well as physical needs be met including:

- The need to be seen by others as an adult who has had a lifetime of experience.
- The need to have others recognize one's uniqueness.
- The need for respect and approval from others.
- The need for self-confidence.
- The need for positive interaction with others.
- The need to preserve one's sense of identity.
- The need for emotional support.
- The need for as much control as possible over one's environment.

Being a resident of a long term care facility does not mean that one must surrender all of one's rights. It also does not mean one becomes totally dependent upon others for care. Staff may inadvertently encourage dependency because it is easier and faster for them to do so for the residents, than to allow time for the residents to do things for themselves. Residents who give up trying to do anything independently often begin to doubt their self-worth, believe that nothing they do matters, and cease making any effort to control their environment. Depression and despair may follow. Studies have shown that nursing home residents' life satisfaction improved when they were given the chance to do more on their own and make more decisions.

Family members also must make adjustments to someone living in a long term care facility. Usually the placement of a relative in a nursing home leaves the family with a mixture of feelings: relief that the ordeal of selecting and choosing a nursing home is over, that the emotional storm raging around whether or not to put the relative in the nursing home has finally been resolved, but also feelings of guilt. No family enjoys having to place a relative in an "institution," no matter how nice a place it may seem to be. The family may feel that it could have or should have prevented either the deterioration of the resident's physical condition or the emotional strains that were placed on everyone involved. Family members may blame themselves and each other for not doing "more" to help cushion the effects of aging, or not taking (or keeping) their parents at home with them. Expressions of family guilt may be expressed in a number of ways—the family may speak to the resident in an angry, babyish, or child-like manner; may make insistent demands on the nursing home staff; or may stay away from the resident.

## **V. Long Term Care Reimbursement**

Who pays for nursing home care? The increasing number of very old and frail persons, the rising costs of health care, and the availability of fewer family members to provide home care combine to make this question a major national concern.

The vast majority of nursing home residents receive Medicaid benefits. Other sources of payment include private pay, Medicare, Veterans Administration benefits, and, in a few cases, private long term care insurance.

### **A. Medicaid**

Medicaid is a medical assistance program for low-income persons. It was established by Title XIX of the Social Security Act of 1965 as a joint Federal -- State program that reimburses providers for covered services to eligible persons.

The Department of Health and Human Services (HHS) administers the program through the Centers for Medicare and Medicaid Services (CMS), which establishes general guidelines for and monitors operation of the program by the states. Both state and federal funds are used in the program, based on a percentage determined by each state's per capita income. States are given some flexibility in deciding what services are covered and who is eligible for Medicaid benefits, so there are differences in Medicaid programs from state to state.

#### **1. Payments by Residents**

A nursing home resident who meets the medical and financial requirements for Medicaid benefits must still pay all of his/her income, except for a personal needs allowance (PNA) (\$70 a month in DC), to the nursing home. In addition to the \$70 PNA per month, residents may pay health insurance premiums from their income and home costs (such as property taxes, insurance, etc.), provided that the home is excluded as a resource.

#### **2. Spousal Impoverishment**

Under the Medicare Catastrophic Coverage Act of 1988, the spouse of a Medicaid-covered nursing home resident can retain all income in his or her name alone and half of the couple's resources up to a maximum that changes annually. If the spouse's income is less than an annually determined amount, the nursing home resident's income up to an annually determined maximum will be paid to the spouse instead of to the nursing home.

The D.C. Medical Assistance Administration, which operates the Medicaid program, can provide the minimum and maximum income and resource allowances permitted by the District for any given year, as well as information on the process for applying for Medicaid nursing home benefits and on the criteria for eligibility.

#### **3. Covered Services**

Under the Medicaid State Plan, nursing homes are required to provide certain services to residents that are included in the Medicaid payment made to the home. These services are listed and discussed in the section on the Nursing Home Regulatory System. Other services covered by Medicaid are listed below. All services must be certified as medically necessary.

### **B. Medicare**

Traditional Medicare consisted of two programs: Part A covers hospital and related care; and Part B covers physicians and other medical expenses. It was established by Title XVIII of the Social Security Act and is administered by a number of agencies. The Social Security Administration handles eligibility determinations. The Centers for Medicare and Medicaid Services (CMS) govern administration of the programs, and private insurance

companies under contract with the government handle actual claims and payments, as well as provide medical insurance services as HMOs.

### 1. Part A

Contrary to what many people believe, Medicare covers very little nursing home care. Medicare pays only for 100 days in a skilled nursing facility. These days must be preceded by a hospitalization of at least three days. The first 20 days are paid in full. Thereafter, the beneficiary must pay a co-payment of \$109.50 per day in 2004. A beneficiary has the right to appeal the denial of Medicare skilled care.

You may deal indirectly with Medicare when assisting a person admitted to the nursing home from a hospital. You may hear the term DRG, which stands for Diagnostic Related Group. This term relates to the Prospective Payment System by which hospitals are paid based on a pre-set rate per case or type of diagnosis. This system, designed to control costs and reward efficiency, has sometimes led to patients being discharged before they have recovered from an illness or procedure and, therefore, who require additional care and/or rehabilitation. Hence they move to a nursing home, rather than return to the community. Reduced hospital stays has been one factor, along with the overall aging of the population, that has shifted the character of nursing homes residents, resulting in a population that is generally older and sicker than in the past.

### 2. Part B

Part B of Medicare is a bit like a major medical insurance policy. It covers the cost of physician services, related medical services, test and supplies, etc. As with Part A, there are deductibles and co-payments. Part B pays for certain items or services for nursing home residents whose facility fee is paid by Medicaid. For example, physical therapy can be billed to Part B for both private pay and Medicaid residents.

Part B payments are based on an allowable charge (also called reasonable or approved charge) -- the amount set by the part B carrier for a specific service. The charges are based on a review of doctors' and suppliers' actual charges in an area during the previous year. Part B pays 80 percent of the allowable charge.

If a provider does not agree to accept Medicare's allowable charge as payment in full, it is called a non-assigned claim. The beneficiary is responsible for any excess amount over the allowable charge, plus the 20 percent co-payment. If the provider agrees to accept the allowable charge as payment in full, he is "accepting assignment." Part B pays 80 percent of the allowable charge, but the beneficiary is responsible only for the 20 percent co-payment. The beneficiary is not responsible for any excess charges. The provider submits the claim directly to the carrier and the carrier pays the provider.

### 3. Part C

Part C of Medicare is called Medicare + Choice. People who are covered by Parts A & B may choose to receive their health care from a private managed care insurance company instead. The private insurance plan must provide the same services covered by Medicare Part A and Part B, but may, in addition, offer additional services for an additional premium. Like any managed care plan, Medicare + Choice plans require that the beneficiary receive care and services from the plan's doctors, clinics, and hospitals.

#### 4. Part D

Beginning in 2006, Medicare beneficiaries will be eligible to enroll in a prescription drug benefit plan through a private company. Initially the monthly premium for the drug plans will be \$35 per month and the yearly deductible will be \$250. Once an individual meets the deductible, he or she will pay 25% of up to \$2,250 in drug expenses. There will be no coverage for drug expenses from \$2,250 through \$5,100. This gap in coverage has been referred to as the “doughnut hole.” Coverage will begin again after an individual has incurred \$5,100 in drug expenses.

Beginning in June 2004, Medicare beneficiaries will be able to purchase a “prescription drug discount card” approved by Medicare but offered by private drug firms and health insurance companies. The card will cost up to \$30 per year for 2004 and 2005. Each card will offer specific discounts on a specific group of prescription drugs. The discounts and drugs offered will be determined by each individual company offering a card and may be changed by the company at any time during the year. Comparison studies provided by some advocacy groups have shown that prices for many drugs through online pharmacies and other group plans are less expensive than those being offered by the cards.

#### **C. Veterans Administration**

The Veterans Administration offers long-term care benefits to veterans enrolled in its health system. Approximately 65,000 veterans receive inpatient long-term care services annually from the VA. Most VA medical centers also provide outpatient long-term care programs.

In 1996, legislative changes created the VA Medical Benefits Package, a standardized health benefits plan available to all enrolled veterans. Veterans can apply for enrollment at any veteran’s benefits office or any VA health Care Facility. Upon enrollment, veterans are placed into one of seven priority groups. Priority 1 veterans are entitled to the maximum amount of services, while priority 7 benefits are more limited. These priority groups are applicable to enrollment only. The actual services available to veterans are not based on the priority groups.

The VA provides long-term care benefits through its own nursing homes care centers, as well as through contracts with community nursing homes and state homes. The VA has contracts with approximately 2,500 community nursing homes and 103 state nursing homes in 47 states. The state nursing home program is based on a joint cost-sharing agreement between the VA, the veteran, and the state.

#### Who is Eligible?

Eligibility for VA nursing home care is quite limited. To be eligible, a veteran must:

- have a service-connected disability rating of 70% or more;
- have a service-connected disability rating of 60% and be unemployable or have an official rating of “permanent and total disabled”;
- have combined disability ratings of 70% or more;
- have a service-connected disability that is clinically determined to require nursing home care;

- have a nonservice-connected disability requiring nursing home care and meet income and asset criteria.

If space and resources are available, other veterans on a case-by-case basis may be eligible, with priority given to those needing care for post-acute rehabilitation, respite, hospice, geriatric evaluation and management, or spinal cord injury.

The VA will provide up to 45 days of nursing home care if there is a hospitalization and a waiting period for the veteran to receive eligibility for Medicaid nursing home services. In some cases, veterans are responsible for paying co-pays of \$97 per day for nursing home services.

#### **D. Long-Term Care Insurance**

You may encounter a resident who has private long term care insurance. In response to the increasing demand for long term care services, insurance companies have developed products that provide coverage for nursing home, assisted living, and/or home health care. These policies are expected to account for an increasing percentage of long term care financing, although most experts believe that they will never represent a major source of payment.

Most policies available are a form of “indemnity” policy, meaning that they pay a set amount per day, week, or month for care. There are tremendous variations in policies as to levels of care covered, periods of care covered, triggering events, exclusions for certain conditions, renewability, deductibles, inflation protection, etc.

### **VI. Regulations Governing Long-Term Care Facilities**

It is important for ombudsmen to understand the standards, procedures, and agencies involved in licensing a nursing home. When complaints come to the Ombudsman Program, the minimum standards contained in federal and state law tell the consumer and the ombudsman what kind of services, care, and environment to expect. If the Program needs to intervene because a home fails to meet those standards, the laws provide guidance on what nursing homes must do to comply with the standards.

#### **A. Federal Regulation/Certification**

In 1987 Congress passed a law called the Nursing Home Quality Reform Amendments of 1987, known in shorthand as OBRA ‘87, since it was a part of the Omnibus Budget Reconciliation Act of 1987. This law phased in many changes in the federal requirements for nursing homes.

##### 1. Certification Requirements for SNFs and NFs

The federal requirements for SNFs and NFs are set by the Centers for Medicare and Medicaid Services (CMS), which was formerly called the Health Care Financing Administration (HCFA), of the U.S. Department of Health and Human Services.

Among the significant changes brought about by the 1987 amendments were:

- The elevation of residents’ rights to a more important requirement within the regulatory system.

- The new requirement for quality of care, which shifts the focus of regulation to improving the quality of care for residents.
- The focus on “attaining or maintaining the highest practicable physical, mental and psychosocial wellbeing” instead of on minimum standards.

To implement these changes, regulations were issued regarding:

- Resident Rights
- Admission, Transfer, and Discharge
- Resident Behavior and Facility Practice
- Quality of Life
- Resident Assessment
- Quality of Care
- Nursing Services
- Dietary Services
- Physician Services
- Specialized Rehabilitative Services
- Dental Services
- Pharmacy Services
- Infection Control
- Physical Environment
- Administration

Another significant change is that the standards required for the old Medicaid Intermediate Care Facilities for the Mentally Retarded (ICFMRs) were made the same as for the Medicaid SNFs. This combined Medicaid SNF and ICFMR facility is called a Nursing Facility (NF). Since NFs are now required to be able to deliver a skilled level of care, the nursing staff requirement was also upgraded.

## 2. Survey Process

The D.C. Department of Health’s Health Regulation Administration (HRA) is the agency under contract to CMS to complete an annual survey of each Medicare and/or Medicaid nursing home in the District to ensure that they meet minimum federal standards. Depending on the size of the home, they spend two or three days inspecting, interviewing residents about their care, reviewing records, observing meal service, and observing the nursing staff pass medications to the residents.

While conducting the survey, HRA personnel record any violations of standards or deficiencies on a federally mandated form. Each deficiency identified is given a scope and severity rating that determines what, if any, remedy or penalty will be imposed on the nursing home. At the exit interview with the home’s administrator, the administrator

proposes how the home will correct any problems identified. This plan of correction is recorded on the same form as the deficiencies.

Surveyors use the following scope and severity grid developed by CMS to rate deficiencies:

Severity of Deficiency	Scope of Deficiency		
<b>CMS Enforcement Grid</b>			
<b>Immediate Jeopardy</b>	<b>J</b>	<b>K</b>	<b>L</b>
<b>Actual Harm</b>	<b>G</b>	<b>H</b>	<b>I</b>
<b>Potential for More than Minimal Harm</b>	<b>D</b>	<b>E</b>	<b>F</b>
<b>No Actual Harm</b>	<b>A</b>	<b>B</b>	<b>C</b>
	<b>Isolated Incident</b>	<b>Pattern of Harm</b>	<b>Widespread Harm</b>

For every deficiency that receives a scope and severity rating of G or higher, HRA can recommend to CMS that a monetary penalty be imposed. In the District, very few facilities have been cited for G or higher deficiencies and, as a result, very few monetary penalties have been imposed.

### **B. State Regulation/Licensure**

The District’s nursing home regulations were repealed in 1994 following a lawsuit against the city for noncompliance of its regulations with federal regulations. Until January 2002, when the District issued new nursing facility licensure rules, the District was the only jurisdiction in the country without local nursing home regulations.<sup>1</sup> Under these rules, a facility found not to be in compliance with District rules can be fined according to the level or class of the violation, in accordance with the District’s schedule of fines for facilities regulated by the Department of Health.<sup>2</sup>

Between January 2002 and January 2004, no implementation of the District’s nursing home regulations occurred. Since January 2004, the Health Regulation Administration has cited some nursing homes for infractions of District nursing facility licensure rules and has imposed some fines. However, specific information about the violations, the nursing homes involved, and amount of fines has not yet been made available.

### **C. Nursing Home Pre-Admission Screening and Annual Resident Review (PASRR)**

Pre-Admission Screening (PAS) is a process to assure that persons seeking admissions to a Medicare/Medicaid certified home do not have a severe mental illness or

<sup>1</sup> See 22 DCMR, Chapter 32.

<sup>2</sup> See 16 DCMR Section 3243.

mental retardation/developmental disabilities. The law requires the state to provide other settings for individuals identified by the screen as inappropriate for nursing home care. The Annual Resident Review (ARR) is the same type of screen process but for current residents of nursing homes.

If a person is denied admission to or asked to leave a nursing home because of the results of the PASARR screen, he/she has a right to appeal this decision. Residents who have resided in a nursing home for 30 months as are entitled to remain in the home.

#### **D. Enforcement in Long-Term Care Facilities**

Ombudsmen need to understand the enforcement process. Complaints registered with the Ombudsman Program often involve a violation of either the state licensure or federal certification standards. Given that resident care and residents' rights are the areas in which most complaints occur, ombudsmen must clearly understand the care standards and residents' rights that facilities are required to provide. Ombudsmen should use the state and federal enforcement systems to advocate for their clients.

##### 1. Types of Enforcement Processes

The Health Regulation Administration (HRA) is mainly responsible for enforcing the state and federal nursing home requirements in the District. Besides conducting annual nursing home surveys, HRA is also responsible for investigating complaints filed with the agency by ombudsmen, residents, family members, and any other members of the public. During a complaint investigation, HRA can survey the entire facility if the inspectors feel it is necessary. The annual survey reports are a matter of public record and must be available in the facility for inspection by the public.

If a facility does not correct a deficiency after a survey, or if the facility has repeatedly violated the same requirement, the state has other enforcement mechanisms it can use including:

- Assessing a fine
- Denying new admissions to the facility
- Placing a monitor in the facility
- Appointing a receiver for the facility
- Denying, refusing or revoking a license
- Suspending a license or issuing a provisional license

The goal of the nursing home enforcement system is not to close down facilities but to ensure that they operate safely. Closing a facility is the last resort since residents' lives are disrupted when they are moved and beds can be difficult to find.

##### 2. "Fast Track" Decertification

Under federal law, CMS can initiate a "fast track" decertification of a Medicare SNF if the deficiencies are "life threatening." Examples of life threatening deficiencies are a non-functioning fire alarm system or improper medication administration resulting in harm to residents. In a "fast track" action, CMS gives the facility 30 days to correct the problem. If the problem is not corrected, CMS will cancel its provider agreement with the nursing home

and stop paying for Medicare recipients. The state would then move to revoke the home's license and cancel the Medicaid agreement, thus stopping both methods of payment. The purpose of the "fast track" is to quickly correct serious deficiencies.

If a "fast track" decertification occurs, or if a nursing home is voluntarily closed or closed by HRA, the Office of the DC Long-Term Care Ombudsman must be notified. While the Ombudsman Program has no regulatory role, it is mandated to protect the rights of the residents. If a home's closure and the moving of residents is imminent, the ombudsman should (1) support and advocate for the residents during the closure process; (2) assure that the residents' choices for relocation are honored; (3) assure that the residents are properly prepared for a move to minimize transfer trauma; and (4) assure legal representation for residents. The ombudsman also frequently serves on a committee composed of the various government, community, and social services agencies that will help in the relocation plan. The ombudsman probably will not actually move anyone, but will fulfill the four roles described above.

3. D.C. Agency Responsible for Nursing Home Regulation and Enforcement

Health Regulation Administration  
D.C. Department of Health  
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