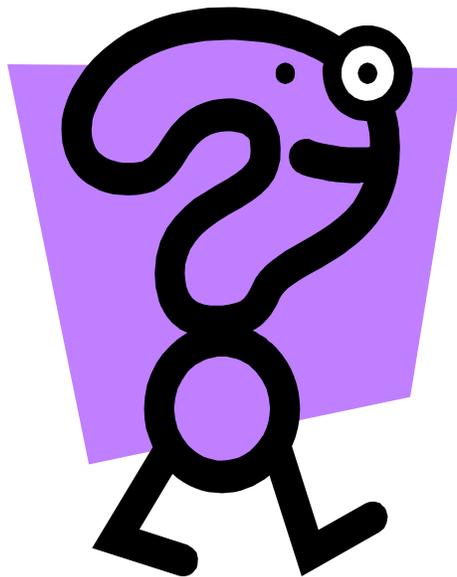


MICHIGAN LONG TERM CARE OMBUDSMAN PROGRAM

FACT SHEETS



BRAD GELLER, EDITOR

SARAH SLOCUM, STATE LONG TERM CARE OMBUDSMAN

MICHIGAN LONG TERM CARE OMBUDSMAN PROGRAM

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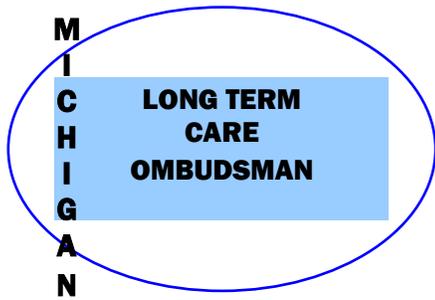
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Fact Sheet

Michigan Long Term Care Ombudsman Program

The Long Term Care Ombudsman Program was created to help address the quality of care and quality of life experienced by residents who reside in licensed long term care facilities such as nursing homes, homes for the aged and adult foster care facilities.

The Michigan Long Term Care Program actively works to improve the long term care system, representing the interests of long term care residents and monitoring the development of federal, state, and local laws, regulations and policies.

The Ombudsman Program is authorized in the Older Americans Act and the Older Michiganians Act.

LOCAL OMBUDSMAN SERVICES

Local Ombudsmen work with individual residents to resolve problems and promote high quality care. They provide a community presence by routinely visiting residents of long term care facilities. Local Ombudsmen are skilled in providing the following:

- Explaining residents' rights

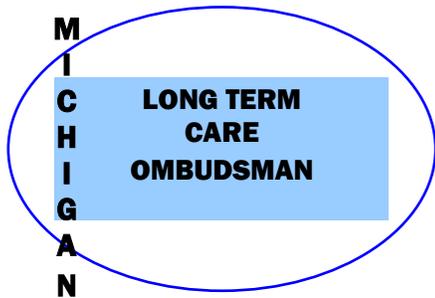
- Empowering residents to communicate their concerns individually or collectively
- Assisting in the resolution of resident concerns
- Promoting community education and awareness regarding long term care issues
- Promoting the use of best practices and,
- Seeking solutions to identified problems within the long term care system.

WHEN TO CALL AN OMBUDSMAN

- When you have unresolved questions or concerns about care in a facility;
- When you have questions about your rights in a long term care facility;
- When you have questions on alternatives to nursing home care;
- When you want to learn more about best practices and creative solutions to problems in long term care settings
- When you are shopping for long term care services;
- When you have questions or need technical expertise on long term care issues;
- When you want to schedule a presentation on issues related to long term care.

For more information please call our toll free number:

1-866-485-9393



Fact Sheet

Access to Residents

The federal government established the Long Term Care Ombudsman program to help resident of long term care facilities who have concerns and complaints about their care or the services they receive. It is the Ombudsman's role to help residents resolve their concerns regardless of how serious the complaint. In order to carry out this role, the Ombudsman has been granted access privileges to long term care facilities in order to meet with residents.

The federal Older Americans Act, which establishes the nationwide network of Long Term Care Ombudsman program, charges local ombudsmen to have **regular** and **timely contact** with residents and requires each state to **ensure** that the local ombudsmen have **access to long term care facilities and residents**.

When

Michigan's Older Michiganians Act puts into effect the mandates of the federal law. This act gives local ombudsmen access to **any long term care facility from 8:00 am to 8:00 pm each day**. Trained volunteer ombudsmen have access to nursing homes during regular visiting hours, and to Homes for the Aged, hospital long term care units, and Adult Foster Care homes from 11:00 am to 7:00 pm.

What

The state act also specifies what it means to have “access”. Local ombudsmen have the right to:

- a) **Enter any facility** and identify himself or herself.
- b) **Seek consent from a resident** to communicate privately and without restriction with that resident.
- c) **Communicate privately and without restrictions with any resident** who consents to communications.
- d) **Observe all resident areas** of the facility except the living area of any resident who protests the observation.

Where

The Older Americans Act defines “long term care facility” as nursing homes certified for Medicare and/or Medicaid, state licensed board and care facilities, or any similar adult care homes. The Administration on Aging has interpreted this definition to mean that under federal law ombudsmen are authorized “...to investigate complaints made by or on behalf of residents of nursing homes, board and care homes, adult residential care facilities, assisted living facilities and any other type of congregate adult care home, the majority of whose residents are age 60 and above, whether or not these facilities are certified to participate in Medicare and Medicaid and/or are regulated by the State.”

Ombudsmen regularly visit nursing homes, meet with residents, and assist residents resolve concerns about their care. Similarly, they are authorized to enter Adult Foster Care Homes and Homes for the Aged to meet with residents.

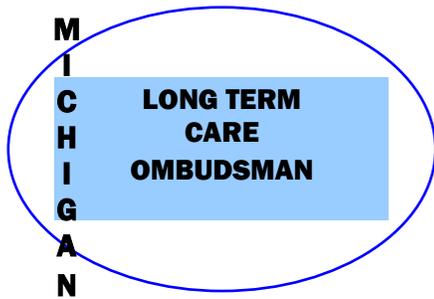
Sources of Law

42 USC 3058g(b)

MCL 400.586i

For more information please call our toll free number:

1-866-485-9393



Fact Sheet

Become a Volunteer Ombudsman

Enlighten yourself...illuminate a life.

Residents in long term care and their families need help getting answers to questions and resolving concerns.

The 100,000 residents in licensed, long-term care facilities in Michigan need someone to provide education, to work toward self-empowerment and to serve as an effective advocate.

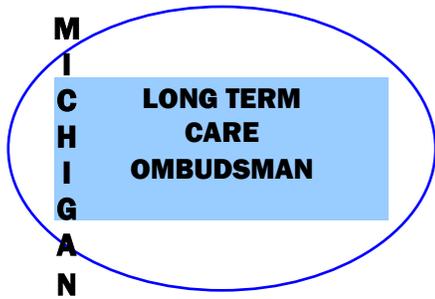
Volunteer ombudsman can help fulfill each of these needs.

Volunteers visit long-term care residents to explain their rights and to report individual complaints about care and service to the Ombudsman.

Volunteers receive intensive training and gain an understanding of the complex long-term care system. Volunteers use these skills to promote improved quality of care and quality of life for residents.

For more information please call: 1-866-485-9393

Or mail us at:
Michigan Long Term Care
Ombudsman Program
300 E. Michigan, 3rd Floor
Lansing, Michigan 48933



Fact Sheet

Options for Long Term Care

Long term care is the phrase used to describe health care and other services that help people with disabilities and chronic illnesses. Individuals with severe diabetes, Alzheimer's Disease, congestive heart failure, or other serious conditions may need long term services.

Long term care can meet a wide variety of needs. Services can be provided in your own home or in residential settings such as nursing homes, homes for the aged, and adult foster care homes. However, determining which services and living arrangements best meet your needs and what options are available and affordable can be complicated and confusing.

This fact sheet is an introduction to long term care services in Michigan, and tells where to find more detailed information. Before you make any decisions about what kind of long term care you will use, fully investigate all your options.

There can be waiting lists for long term care services. You may want to place your name on the waiting lists for those services you will need. Sometimes the need for long term care arises suddenly or unexpectedly, and decisions must be made quickly. Even under these circumstances, you can be an active participant in planning for long term care.

In-Home Services

Help is available for you to stay in your own home. Help can come from family members, friends, churches, and public and private agencies. You may need different kinds of help each day, week, or month.

Paying for in-home services can be complicated and expensive. No private insurance or government agency pays for around the clock in-home care. Most government programs and insurance pay for short daily or weekly visits or services.

Some services are available at little or no cost for those who qualify through an Area Agency on Aging, the Veterans Administration, Medicare, Medicaid, the Michigan Department of Human Services, and other sources. Medicaid pays for some health care costs for low-income individuals of any age. Medicare pays health care expenses for individuals at least 65 years old, and for individuals who have permanent disabilities, regardless of income or assets.

The following list describes the kind of in-home care services which help older adults and others stay at home. Your local Area Agency on Aging can help you find these services.

Home and Community Based Waiver Services - Medicaid funded services provided in your home which prevent or delay the need for nursing home care. To be eligible for this service, you must meet certain income and asset limitations, need the type of services available in a nursing home.

Care Management - This program is designed to aid the frail older adult to remain at home by assessing needs and then helping to arrange in-home long term care services to meet those needs.

Home Health Services - Two basic types of services are offered by home health agencies: 1) Home Nursing Care is provided by nurses. Services include changing dressings, administering prescribed medications and injections, and other services. It is usually a time-limited service to monitor medical instability. 2) Personal Care Services include administering medications, bathing, dressing, and meal preparation. Aides provide the service and are supervised by nurses.

Home-Delivered Meals -This service provides one or more meals a day delivered to your home, five to seven days per week. It is sometimes called Meals-On-Wheels. AAAs fund this service at no charge to you but may request a donation. Eligibility, in most cases, is based solely on age -but there may be waiting lists. Other agencies also provide this service but usually charge a fee.

Homemaker and Home Chore Services - These services help take care of the home and include meal preparation, laundry, shopping, light house cleaning, and in some cases, companionship.

Home Repair, Maintenance, and Security - This service covers minor home repairs and improvements such as constructing wheelchair ramps, weatherization, clearing drains, repairing roof leaks, plumbing, furnaces, and adding security devices.

Respite Care - A qualified person comes to the home, or you go to another location, to temporarily relieve the family caregiver.

Services Outside Your Home

Adult Day Care Services - This program is for individuals who need daytime supervision and social activities. Adult day care can provide respite

care outside your home. It is helpful to family caregivers who work or who simply need a break from care giving.

Congregate Meals - hot lunch as well as other activities at community centers.

Housing Options

Senior Citizen Apartments - Senior housing is operated by for-profit corporations and non-profit commissions. In government-subsidized units, rent is based on your income. Your rent will not exceed 30 percent of your monthly income. Long waiting lists are typical for subsidized housing in some areas.

Many of the in-home services described in the previous section are also available to people living in senior citizen housing. Your Area Agency on Aging can help you find out more about senior housing.

"Assisted Living" - Assisted Living is a marketing term used to describe a kind of residential care program. There are some businesses not licensed or inspected by the state which market and provide "assisted living." Be careful to read all information about costs and services very carefully, and look at options before committing yourself to live at one of these residences. The rights and obligations of the resident and the facility should be spelled out in the contract you sign.

Adult Foster Care (AFC) homes are licensed and inspected by the state. AFC homes provide room and board, special diets, supervision and some personal care to adults who are frail but in generally good health. Personal care includes help with bathing, dressing, and taking medications.

Some AFC homes specialize in care for older adults, individuals with a developmental disability, or the individuals with a mental illness. There are usually fewer than 20 residents; many homes have fewer than 6.

Most AFC homes are private pay and do not accept Supplemental Security Income (SSI) as full payment. Residents pay for their care with Social Security, pensions, other income, and savings.

Homes for the Aged (HFAs) provide the same level of care as AFC homes. Absent a waiver, HFAs only serve people who are at least 60 years old. They are larger than AFCs, with 50 to 300 residents. Residents of HFAs use their income and savings to pay for services. Like AFC homes, HFAs do not provide daily medical care, although some may provide nursing care on a limited basis.

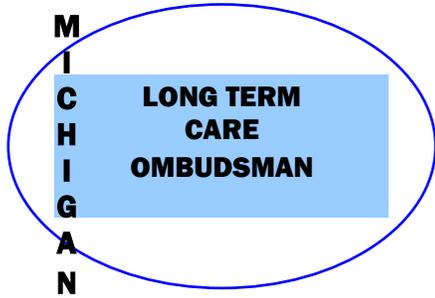
Nursing homes are for individuals who need nursing care and more personal care than can be provided in another setting. Many individuals turn to a nursing home when their income and savings cannot cover other long term care options, when family members can no longer play a major role in care-giving, or when they have 24-hour nursing needs.

Most residents receive **basic care**: help with bathing, toileting, feeding, dressing, medication, skin care, and walking. Basic care also includes observation and assessment of health needs, such as watching for infections and serious illness.

Skilled care means the resident needs the daily attention of a licensed health professional such as a registered nurse, practical nurse, or physical therapist under orders from a doctor. Skilled care may include intravenous (IV) feedings or medication, colostomy care, treatment of severe bed sores, physical therapy, or observation and assessment of a changing or unstable condition.

Medicaid can pay for both skilled and basic care; Medicare covers only skilled care, and only on a short term basis.

For more information, read the fact sheet, *How to Choose a Nursing Home*, and contact the Michigan Long Term Care Ombudsman Program, toll-free, **1-866-485-9393**.



Fact Sheet

Medicare Hospital Discharge Rights

When you are in the hospital using Medicare benefits, you have certain rights related to your discharge. If you feel you are being discharged too soon, you may appeal the discharge decision.

It is important to use this appeal process **BEFORE** you leave the hospital. Once you are physically outside the hospital these rights are gone.

What to do?

There is a simple, three-step process to start your appeal of discharge:

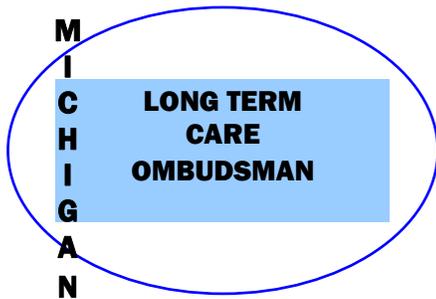
1. **Just Say NO.** Do not leave the hospital; do not agree to the discharge; clearly state your opposition to discharge at that time.
2. **Get It In Writing.** You are entitled to a written notice, called a Notice of Non-Coverage. This piece of paper is your official notice of the end of Medicare payment for your hospital stay and includes the toll free number for MPRO.
3. **Call MPRO!** You must call the MPRO toll free number, **1-800-365-5899** by noon of the next business day to use your appeal rights.

You do not have to pay for hospital days while MPRO is reading your medical record and deciding your appeal. If MPRO decides that discharge is appropriate, you **WILL** have to pay for days after that decision is made if you choose to stay in the hospital.

People with Medicaid, but not Medicare, do not have these same rights. Other advocacy strategies will be needed to help people in this situation, including negotiation with the discharge planner and/or supervisors, and working toward early intervention (discharge planning starts on the day of admission) for all consumers.

For more details on this process you can call MPRO at **1-800-365-5899**.

For help with advocacy in this area, call the Long Term Care Ombudsman Program at **1-866-485-9393**.



Fact Sheet

MI-Choice Waiver Program and Home Help Program

What is *Medicaid*?

Medicaid is a program funded by the federal and state governments and administered by the Michigan Department of Human Services (DHS). Upon you completing a Medicaid application, DHS determines your eligibility.

Is Medicaid the same *Medicare*?

No. Medicare is funded by the federal government, and is available to older adults and individuals with long term disability. Eligibility for Medicare is not based on your income or the value of your assets.

What is the *MI-Choice Waiver Program*?

Traditionally, Medicaid only covered long-term care services in a nursing home. Some years ago, Michigan began a program by which Medicaid would pay for long term care services for qualifying individuals - older adults and younger adults with a disability - in their own house or apartment.

The program is also known as *MI-Choice*, the *Home and Community Based Waiver Program* or simply the *Waiver Program*.

What is the purpose of MI-Choice?

The program gives an opportunity for individuals who need a *nursing home level of care* to remain in their own homes, or to return to their own homes, while receiving services there.

What services are available through the MI- Choice?

Examples are personal care; meal preparation and home delivered meals; private duty nursing and specialized durable medical equipment; respite care and non-medical transportation; home modifications and housekeeping-type chores.

You will be assessed to determine what services you need. You can choose the service providers or have the *waiver agent* arrange for providers.

What if I live in an adult foster care home or home for the aged?

You can now receive MI-Choice services in those settings.

If I live in unlicensed “assisted living,” is MI-Choice available?

Yes.

Can I be forced to participate in MI-Choice?

No. If you are eligible, you decide whether or not to participate. If you choose to participate, you determine where you would like to live, based on what you can afford and what setting best meets your needs and wishes.

Who qualifies for MI-Choice?

First, you need to meet the level of care available in a nursing home. You will be asked a number of questions about your need for assistance with certain daily activities.

Second, despite needing the level of care available in a nursing home, you must be able to live outside a nursing home, with supportive services.

You must need at least one waiver service on a regular basis.

Are there any other requirements?

Yes. You must be financially eligible for Medicaid, which is determined through application to the local Department of Human Services office.

What are the financial eligibility requirements?

If you are single, your *countable assets* cannot be more than \$2,000. The value of your home, an automobile and a pre-paid funeral are not countable assets.

Your monthly income must be \$2,094 per month or less.

What if I am married?

Different financial eligibility rules apply if you are married, allowing you to have higher assets and still be eligible. Your spouse's income is not considered in determining your eligibility.

How much will waiver services cost me?

Currently, there are no co-pays for these services, so there will be no out-of-pocket costs for you.

Who decides if I meet a nursing home level of care?

The decision is made through a *waiver agent*, after an evaluation. The actual evaluation, known as an *assessment*, will be determined by a nurse and social worker. They determine whether you need a nursing home level of care, and what waiver services you both need and want. You have a right to see your assessment once completed.

A list of waiver agents covering different counties in the state is at the end of this fact sheet. You often have a choice of two different organizations that serve as waiver agents.

How long will it take for the Department of Human Services (DHS) to determine if I am eligible for Medicaid?

First, it depends if you submit all requested paperwork during the application process. If you do so, your application should be processed within 45 days, but it may take longer.

Once I am enrolled in Medicaid and determined eligible for waiver services, will I begin to receive services immediately?

Unfortunately, there can be a long waiting list. Whether there is a waiting list, and the length of the list, is different in each county.

Therefore, it is a good idea to apply for waiver services as soon as it appears you may need a nursing home level of care. You can apply for waiver services even before you apply for Medicaid

What is the *Nursing Facility Transition Initiative (NFTI)*?

NFTI is part of the Waiver Program. NFTI is designed to help nursing home residents move back to the community, with supportive services

Where can nursing home residents move to, and be eligible for Waiver services?

A nursing resident can move back to his or her home, an apartment, an adult foster care home, a home for the aged or to other assisted living.

Is there a waiting list for NFTI?

Although there can be a long waiting list for Waiver Services, individuals already in a nursing home have priority, and should be served relatively promptly.

Who determines eligibility?

You must need a nursing home level of care, but be able to live in the community, and need at least one waiver service on a continual basis. This determination is made through an assessment by a waiver agent.

If an individual is in a nursing home, how would she or he become connected to the NFTI program?

Federal law requires nursing home staff to annually assess each resident. As part of that assessment, known as the *Minimum Data Set (MDS)*, residents must be asked if they are interested in moving back to the community.

If the individual expresses a desire to move to the community, nursing home staff have an obligation to contact the waiver agent to conduct an assessment.

You can at any time contact a waiver agent and ask her or him to visit you to discuss NFTI.

Can a guardian prevent the nursing home staff from asking the resident about her or his wishes, or prevent an assessment?

No. A nursing home is to first question the resident.

If the resident is interested in moving from the nursing home, the guardian should cooperate with the waiver agent. A guardian has a responsibility to obtain services to bring the individual back to the degree of self-care possible; this includes moving to a less restrictive environment.

A guardian does have the final say whether the individual moves from the nursing home.

What is *Home Help*?

Home Help is another Medicaid program administered by the Michigan Department of Human Services. Application for Medicaid must be made through the county DHS office.

What services are available through Home Help?

One set of services is assistance with activities of daily living, including bathing, toileting, eating and transferring from bed to chair.

Other services include meal preparation, medication management, light house cleaning, laundry and shopping.

Who is eligible?

First, you must need help with *an activity of daily living*, such as a service listed in the first paragraph above.

The relatively simple, additional application for Home Help must be accompanied by a brief medical form signed by a qualified medical professional.

You will then be visited by an adult services worker who will do an assessment to determine the type of help the individual needs – which services and how many hours per week for each service.

Where can I live and be able to receive Home Help services?

You can receive these services if you are living in a house or apartment.

What are the financial eligibility criteria?

You must be enrolled in Medicaid. There are no further financial eligibility requirements.

Who performs the services I need?

You can choose the provider, which can be a business, a friend of yours or a family member, but not your spouse. The Department of Human Services office sets the amount the provider gets paid.

How much will Home Help services cost me?

There will be no cost to you.

Is there a waiting list to receive Home Help services?

No.

Will the Waiver Program or the Home Help Program cover rent for the individual?

No. But there may be other government programs to help with rent, such as *Section 8*.

Can an individual receive Home Help services and Waiver Services at the same time?

No.

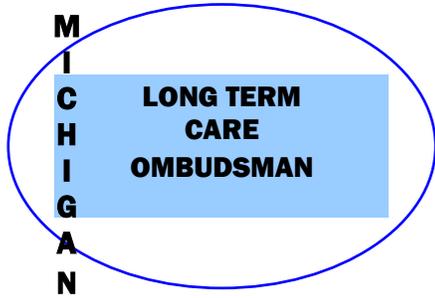
If I receive waiver services, might I have to pay the state of Michigan back when I die?

Yes, you might. Michigan and all states have a program of estate recovery. For more details, request the Fact Sheet on estate recovery from the Long Term care Ombudsman Program, 1-(866) 485-9393.

The Department of Human Services has an obligation to inform you about estate recovery when you apply for Medicaid.

Are there other programs that can help pay for services similar to those discussed in this fact sheet?

Yes. There are *Aid and Attendance benefits* through the Veterans Administration, the *Program of All-Inclusive Care for the Elderly (PACE)*, and other Medicaid waiver programs, including programs for individuals with developmental disabilities and mental illness.



Fact Sheet

Gamut of MI Choice Services

<p>MINIMUM OPERATING STANDARDS FOR MI CHOICE WAIVER PROGRAM SERVICES-DEFINITIONS OF SERVICES</p> <p>(Standards Last Revised 09/17/09)</p>	
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<p>ADULT DAY HEALTH (Adult Day Care)</p>	<p>Services furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, or as specified in the service plan, in a non-institutional, community based setting, encompassing both health and social services needed to ensure the optimal functioning of the participant. Meals provided as part of these services shall not constitute a “full nutritional regimen” (3 meals per day). Physical, occupational and speech therapies will be furnished as component parts of this service. Transportation between the participant’s place of residence and the Adult Day Health center will be provided as a component part of this service.</p>
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CHORE SERVICES

Services needed to maintain the home in a clean, sanitary, and safe environment. This service includes heavy household chores such as washing floors, windows, and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress inside the home. This service also includes yard maintenance (mowing, raking and clearing hazardous debris such as fallen branches and trees) and snow plowing to provide safe access and egress outside of the home. These services are provided only in cases when neither the participant, nor anyone else in the household, is capable of performing or financially providing for them and where no other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

COMMUNITY LIVING SUPPORTS

Community Living Supports facilitate an individual's independence and promote reasonable participation in the community. Community Living Supports can be provided in the participant's residence or in community settings as necessary in order to meet support and services needs sufficient to address nursing facility level of care needs.

<p>COUNSELING SERVICES</p>	<p>Professional level counseling services seek to improve the individual's emotional and social well-being through the resolution of personal problems and/or change in an individual's social situation.</p>
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<p>ENVIRONMENTAL ACCESSIBILITY ADAPTIONS</p>	<p>Those physical adaptations to the home, required by the participant's service plan, that are necessary to ensure the health and welfare of the participant or that enables the participant to function with greater independence in the home, without which, the participant would require institutionalization. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant. Excluded are those adaptations or improvements to the home that are not of general utility, and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation. All services shall be provided in accordance with applicable State or local building codes.</p>
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FISCAL INTERMEDIARY SERVICES

Service that assists the adult participant, or a representative identified in the participant's plan of care to prevent institutionalization by living independently in the community while controlling his/her individual budget and choosing the staff to work with him/her. The Fiscal Intermediary helps the individual to manage and distribute funds contained in the individual budget. The participant uses funds to purchase waiver goods and services authorized in the individual plan of services. Fiscal Intermediary services include, but are not limited to, the facilitation of the employment of service workers by the individual, including federal, state, and local tax withholding/payments, unemployment compensation fees, wage settlements; fiscal accounting; tracking and monitoring participant-directed budget expenditures and identify potential over and under expenditures; assuring compliance with documentation requirements related to management of public funds. The Fiscal Intermediary may also perform other supportive functions that enable the participant to self-direct needed services and supports. These functions may include verification of provider qualification, including reference and background checks and assisting the participant to understand billing and documentation requirements. The Fiscal Intermediary may also provide services that assist the participant to meet the need for services defined in the plan of care while controlling an individual budget and choosing staff authorized by the waiver

	<p>agent. The fiscal intermediary helps the individual manage and distribute funds contained in the individual budget.</p>
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<p>GOODS AND SERVICES</p>	<p>Goods and services are services, equipment, or supplies not otherwise available through the MI Choice waiver or the Medicaid State Plan that address an identified need in the individual plan of care, including improving and maintaining the participant's opportunities for full membership in the community.</p>
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<p>HOME DELIVERED MEALS</p>	<p>Home delivered meals (HDM) is the provision of at least one nutritionally sound meal per day to persons who are dependent, aged, or physically disabled and unable to care for their nutritional needs. The unit of service is one meal delivered to the participant's home or to the participant's selected congregate meal site that provides a minimum of one-third of the current recommended dietary allowance (RDA) for the age group as established by the Food and Nutritional Board of the National Research Counsel of the National Academy of Sciences. Allowances shall be made in HDMs for specialized or therapeutic diets, as indicated in the plan of care. A Home delivered meals shall not constitute a full nutritional regimen.</p>
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<p>HOMEMAKER</p>	<p>Services consisting of the performance of general household tasks, (e.g., meal preparation and routine household cleaning and maintenance) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and upkeep for him or herself or others in the home. This service also includes observing and reporting any change in the participant's condition and the home environment to the supports coordinator.</p>
<p>NON-MEDICAL TRANSPORTATION</p>	<p>Services offered to enable waiver participants to gain access to waiver and other community services, activities and resources, specified by the service plan. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and does not replace them. Transportation services under the waiver are offered in accordance with the participant's individual plan of service. Whenever possible, family, neighbors, friends, or community agencies, that can provide this service without charge is utilized.</p>
<p>NURSING FACILITY TRANSITION (NFT)</p>	<p>Nursing Facility Transition services are non-reoccurring expenses for persons transitioning from a nursing facility to another living arrangement in a private residence where the person is responsible for his or her own living arrangement.</p>

PERSONAL EMERGENCY RESPONSE SYSTEM	PERS is an electronic device that enables waiver participants to secure help in an emergency. The participant may also wear a portable “help” button to allow for mobility. The system is connected to the participant’s phone and programmed to signal a response center once a “help” button is activated. The response center is staffed by trained professionals, as specified in Appendix B-2. Installation, upkeep, and maintenance of devices/systems are also provided.
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PERSONAL CARE WAIVER	A range of assistance to enable program participants to accomplish tasks that they would normally do for themselves if they did not have a disability. This may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the participant to perform a task. Health-related services that are provided may include skilled or nursing care to the extent permitted by State law. Personal Care includes assistance with eating, bathing, dressing, personal hygiene, and activities of daily living. This service may include assistance with preparation of meals, but does not include the cost of the meals themselves. When specified in the plan of care, this service may also include such housekeeping chores as bed making, dusting and vacuuming, which are incidental to the service furnished, or which are essential to the health and welfare of the individual, rather than the individual’s family. Personal care may be furnished outside the participant’s home. The participant
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	<p>oversees and supervises individual providers on an on-going basis when participating in self-determination options.</p>
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<p>PRIVATE DUTY NURSING</p>	<p>Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of State law. These services are provided to an individual at home. PDN for waiver participants 18-21 years old are provided by the Medicaid State plan. PDN services for participants older than 21 years are not available through the Medicaid State plan.</p>
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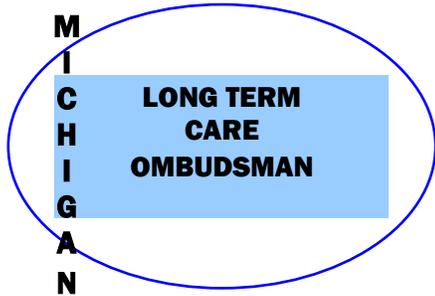
<p>RESIDENTIAL SERVICES</p>	<p>Residential services include enhanced assistance with activities of daily living and supportive services. MI Choice participants who receive this service must reside in licensed homelike, non-institutional settings. These settings include continuous on-site response capability to meet scheduled or unpredictable resident needs and provide supervision, safety, and security. Third parties may only furnish this service with the approval of the participant, licensee, and waiver agent. Payment excludes room and board, items of comfort or convenience, and costs of facility maintenance, upkeep and improvement.</p>
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<p>RESPITE PROVIDED INSIDE THE HOME</p>	<p>Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care for the participant. Services are provided in the participant's home or a private place of residence.</p>
<p>RESPITE PROVIDED OUTSIDE OF THE HOME</p>	<p>Services provided to participants unable to care for themselves furnished on a short-term basis because of the need for relief of the usual caregiver. Federal financial participation is not claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence. Respite care may be provided in a Medicaid certified hospital or a licensed Adult Foster Care home.</p>
<p>SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES</p>	<p>Specialized medical equipment and supplies include devices, controls, or appliances, specified in the plan of care, that enable participants to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment and medical supplies not available under the Medicaid State</p>

	<p>plan that are necessary to address participant functional limitations. All items shall meet applicable standards of manufacture, design, and installation. Waiver funds are also used to cover the costs of maintenance and upkeep of equipment. The coverage includes training the participant or caregivers in the operation and/or maintenance of the equipment or the use of a supply when initially purchased.</p>
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<p>TRAINING</p>	<p>Training services are instruction provided to a waiver participant or caregiver in either a one-to-one situation or a group basis to teach a variety of independent living skills, including the use of specialized or adaptive equipment or medically-related procedures required to maintain the participant in a home or community-based setting. The training needs must be identified in the comprehensive assessment or in a professional evaluation and included in the plan of care as a required service. Training in the following areas will be covered: activities of daily living; adjustment to home or community living; adjustment to mobility impairment; adjustment to serious impairment; management of personal care needs; the development of skills to deal with service providers and attendants; effective use of adaptive equipment. For participants self-directing services, training may also include the training of independent supports brokers, developing and managing individual budgets, staff hiring and supervision or other areas related to self-direction.</p>
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Fact Sheet

MI Choice Waiver Complaints

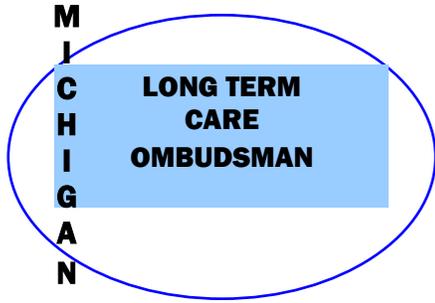
If you have a complaint about your services, you have a right to file a complaint with the Waiver Program.

As a recommended process for resolving your complaint effectively, follow the following steps:

1. Inform your care manager. If your complaint is about your care manager, ask to speak with the care management supervisor. It is your waiver agent's responsibility to assist you and resolve concerns about your care and services.
2. Contact the Department of Community Health contract manager, Elizabeth Gallagher, at **517-335-5068**. The contract manager is the State's liaison between the waiver agents and the State.
3. Contact an advocacy organization for assistance in filing your complaint
 - Michigan Long Term Care Ombudsman Program **1-866-485-9393**
 - Michigan Protection and Advocacy Service, Inc. **1-800-288-5923**

General suggestions:

Write down whom you spoke to about your concerns including the date and time. If possible, you should put complaint in writing and keep a copy for your records.



Fact Sheet

How to Choose a Nursing Home

The need for a nursing home may result from a serious illness, an accident, a chronic condition, or when family caregivers can no longer provide adequate care. Planning is very helpful, but many people only start looking for a nursing home during a crisis. Having a plan can help reduce the stress and uncertainty of the task.

If you are planning care for someone other than yourself, it is very important to include the person needing care in the decisions. For a more successful adjustment, the prospective resident should be involved in the process of selecting the home, with consideration of her or his preferences.

A plan should include gathering information, visiting, and evaluating options. Factors to consider are location; availability; affordability; quality; and “what is it like being a resident here?”

Location

You will need a list of local nursing homes. Many facilities may use names such as "care center", "extended care facility", "rehabilitation center", or something similar instead of "nursing home." Your Local Ombudsman can give you a list of all the residences in your area licensed as nursing homes. You can reach your local ombudsman by calling, toll-free, **1-866-485-9393**.

If you are in the hospital, talk with the social worker or discharge planner. The social worker may also refer you to the Local Ombudsman for assistance.

Availability

Some nursing homes may have all beds filled, and have established a waiting list. If this is a home you wish, it is important to put your name on the list.

Affordability

Nursing home care can cost as much as \$4,000 - \$8,000 per month. You need to consider how the cost of care would be paid. **Medicare** only pays for a limited amount of time when skilled services are required following a hospital stay. If you have **long-term care insurance**, the insurance should reimburse at least part of the cost. When your savings are nearly exhausted, **Medicaid** can supplement your income in paying for nursing home care. (If you are married, different eligibility rules apply to Medicaid.)

Be aware that a home may participate in Medicaid, but still not accept an applicant who is already enrolled in Medicaid. And a nursing home might have only some of its beds certified for Medicaid; in such case, a resident may have to move upon becoming eligible for Medicaid. It is important to check with the nursing home on these points.

A nursing home can never require a family member to guarantee private payment as a condition of admitting a resident.

Quality of Care

If you have access to the internet, visit Medicare's website, www.medicare.gov, and then click on "Nursing Home Compare".

This site lists all the nursing homes that participate in Medicare and indicates whether the home also participates in Medicaid. There are abbreviated state inspection reports and information on staffing. In addition, the site rates the homes in 15 areas known as Quality Measures. These ratings are based on information that the homes provide to Medicare.

A second source of information is “word of mouth:” talk to friends and neighbors about experiences a family member of theirs may have had in a particular home.

Another aspect of quality is the availability, qualifications for and delivery of services in addition to medical and nursing care. You will need to visit the nursing home and speak to the admissions coordinator about dental, eye and hearing care; physical, speech, and occupational therapy; social and mental health services to address adjustment issues, inappropriate behavior, anxiety, fear, depression, and grief.

What is it Like Being a Resident Here?

Visiting nursing homes is the most important part of choosing one. It gives you an opportunity to observe the quality of life and care in the facility.

Make an appointment with the admissions coordinator. This will give you an opportunity to ask questions about admission policies and procedures as well as to briefly see the home. Ask questions tailored to your loved one’s needs.

Ask for a copy of the admissions contract so you can carefully review it later. The contract describes the services you receive, your rights and responsibilities, and the charges for your care.

After the tour, ask if you may take more time at the home on your own, or return on a different day to tour on your own. During your visit, talk to residents

and their families, if possible, to get their insights about being a resident here. Some of your questions will be answered through your own observations; other questions will need to be answered by staff.

Many factors affect quality of care and quality of life of a resident. In a visit or two, you cannot observe or determine them all. You might focus on the following -

Attitude and activity of staff

Pay special attention to how staff members interact with and treat residents. Do they respond to resident needs in a timely way and in a courteous and respectful manner? Does there appear to be enough staff? Observe whether residents are dressed appropriately; the men shaven, resident's hair brushed or combed.

Do residents and staff appear happy?

Residents should be encouraged to maintain, regain, or improve their abilities. Look for signs that nursing and therapy staff attends to residents' needs in a way that promotes independence.

Physical environment

Nursing homes must strive to create as home-like environment as possible. Are rooms and public spaces well lit, clean and free from odors? Do resident rooms provide for privacy? Do residents have personal furnishings and decorations in their room? Do residents have access to private space outside their room?

Medical care

You have the right to have your own doctor. If you do not, the medical director of the nursing home will be your doctor. What is her or his name and experience? How often does she or he visit each resident? Who comes to the home in emergencies?

Is there a program for the prevention and treatment of incontinence? Is there daily attention to oral hygiene?

Are residents and their family members encouraged to participate in forming an individualized plan of care?

Activities

Are resident engaged in activities, or sitting in the hall or lying in bed? Are small day or activity rooms available and in use? Are residents free to move or are they restrained in any way?

Look for a posted activity calendar. What social and recreational services are offered; how often do they occur; are they available during the evenings and on weekends? If you are touring during a scheduled activity, is the activity in progress? How many residents are participating? Ask if you can observe without being intrusive.

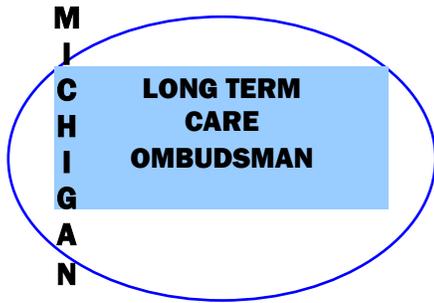
Are residents permitted to sit or walk outside during a beautiful day? Are there sufficient staff to afford residents this opportunity?

Excursions with staff outside the nursing home – to parks, museums and ballgames – should be made available.

A nursing home may advertise a special unit, such as one for residents with dementia. Check what specific programs and activities are available to residents on that unit that make it different. What type of training do staff receive to work with residents on the specialized unit?

Food

Food is an area where we all have individual needs and preferences. Visit during a meal and observe all aspects of the dining experience. Look at posted menus; are there foods you like? Do residents have a choice what to eat? Does the food look appetizing? Do residents appear to be enjoying the food? Are aides helping people who need assistance? Ask to speak with the dietitian if you need a special diet.



Fact Sheet

Nursing Home Checklist

Cost

- Is the facility's daily rate reasonable?
- Are there extra charges beyond the daily rate?
- Is financial assistance (Medicare, Medicaid) available?
- Do I have to guarantee payment out of my own funds?

Environment

- Is the facility clean, tidy, and free of odor?
- Is the facility homelike? Or is it very institutional?
- Are small day or activity rooms available and in use?
- Are residents encouraged to bring personal possessions?
- Are there safe indoor and outdoor areas available?
- Do residents have access to private space? Private use of a telephone?

Meals

- Do meals meet residents' dietary needs and accommodate their preferences?
- Do residents receive assistance with meals as needed?
- Are residents given sufficient fluids?

Staffing

- Do staff members have necessary skills?
- Does the facility appear to have enough of a staff?
- Does the staff receive orientation and ongoing training?
- Is the staff stable? Or is there a lot of turnover?
- Does the staff seem to have a caring attitude?
- Is there an atmosphere of warmth and friendliness?
- Are social services available? What kind of assistance is provided?

Continence

- What is the facility's toileting program?

Care

- How does the facility use physical and chemical (psychotropic drugs) restraints?
- Who will be the resident's attending physician? Is he or she readily available?
- Are mental health services available and delivered as needed?
- Are residents well groomed?
- Will the facility meet all of the person's care needs for therapy and other specialized services?
- Are staff trained in preventive and oral hygiene care? Is care provided daily?
- Are residents and their family members encouraged to participate in forming the plan of care?

Residents' Rights

- Are residents treated with dignity and respect?
- Are privacy needs met?
- Were you given information about other resident rights?

Activities

- Do residents appear active and involved in life in the facility?

- Is there a regular program of activities?
- Is there a qualified staff person to coordinate activities?
- Are their joint activities for residents and families?

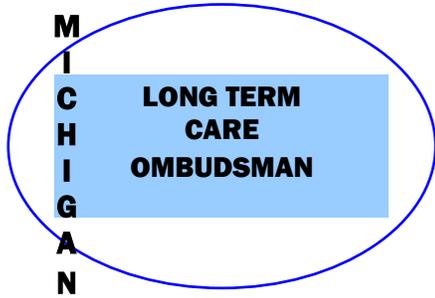
Transfers and Discharge

- Did the facility explain when transfers are required?
- Are residents transferred or discharged from the facility when their money runs out?
- Are residents transferred or discharged from the facility when their care needs increase?

Family Involvement

- How are families involved?
- Does the facility involve the family in creating a comprehensive, individualized care plan?
- Are family members allowed to make treatment decisions? Under what circumstances?
- Is there an active family council?

For more information please call our toll free number: **1-866-485-9393**



Fact Sheet

Medicaid LTC Eligibility Screening

Michigan uses an electronic web-based screening tool to decide whether **Medicaid-eligible** individuals are eligible for nursing facility level of care in a long-term care facility, the MI Choice or PACE programs.

All **Medicaid-eligible** individuals seeking admission to a nursing facility, the MI Choice program, or the PACE program or seeking re-certification of Medicaid must now be screened in seven areas (sometimes referred to as "doors").

1. Activities of Daily Living
2. Cognitive Performance
3. Physician Involvement
4. Treatments and Conditions
5. Skilled Rehabilitation Therapies
6. Behavior
7. Service Dependency

Medicaid-eligible individuals who must be screened include:

- Those already residing in a facility who have just qualified for Medicaid

- ❑ Those already qualified for Medicaid who have completed or declined Medicare-funded rehabilitation and who are returning to Medicaid financed long term care services
- ❑ Non-emergency transfers from another nursing facility where they had been receiving Medicaid coverage

If an individual qualifies under at least one of the seven areas, she or he is eligible to receive Medicaid-financed long term care services.

If an individual is determined not to need nursing facility level of care in ANY of the seven screening areas, there are three ways to request a review of the screening:

Request for another screening

If you feel the first screening was not accurate because it contained incorrect or incomplete information about your needs, you may request that the screening be redone. It is not necessary to wait any specific time period before requesting a second screening. It may be requested the same day as the first screening.

If you qualify under the second screening, the Michigan Department of Community Health may conduct a review of your medical records to ensure that the second screening was accurate.

Immediate review

The service provider or you (if the service provider does not do so) may request an **immediate review** from the Michigan Peer Review Organization (MPRO), which is the designated agent to decide whether the person will receive

an **exception** allowing them to continue to receive Medicaid services. You must act before noon of the day after you are told.

MPRO will review your medical records and other information to determine whether your needs could be met outside a nursing facility or the MI Choice program or PACE. MPRO may decide to issue an exception allowing you to be admitted to the nursing facility or MI Choice or PACE. If MPRO refuses the exception, you will receive written notice.

Medicaid Fair Hearing

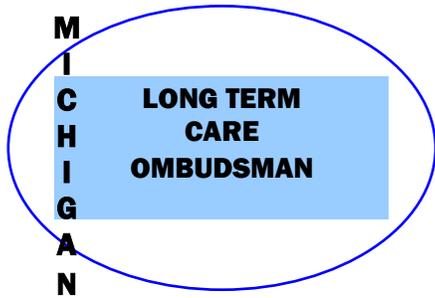
If MPRO refuses the exception, you can request a Medicaid Fair Hearing. To request a Medicaid Fair Hearing, you must complete a "Request for an Administrative Hearing" (DCH-0092) form and mail it to -

Administrative Tribunal
Michigan Department of Community Health
P.O. Box 30763
Lansing, Michigan 48909

The Medicaid Fair Hearing Request must be received within 90 days of the date of the notice from MPRO.

For more information please call our toll free number:

1-866-485-9393



Fact Sheet

Your Rights as a Resident in a Nursing Home

Federal and State Laws Protect Your Rights

Your rights as a resident of a nursing facility are guaranteed by the federal 1987 Nursing Home Reform Law, and my state law. The federal law requires nursing homes to “**promote and protect the rights of each resident**” and places a strong emphasis on individual dignity and self-determination. Nursing homes must meet federal residents’ rights in state law or regulation for nursing homes. A person living in a nursing home maintains the rights he or she had before becoming a resident of the facility.

All nursing homes are required “to provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with written plan of care that is prepared with the participation of the resident, the resident’s family, or legal representative.

Your Right to Dignity & Respect

You have a right to -

- Reasonable accommodations of individual needs and preferences
- Appropriate and timely medical and personal care based on your needs and preferences

- Be protected from any kind of abuse, harsh treatment, neglect
- Be free from any kind of restraint (physical or chemical) used for convenience or discipline and not used to treat medical symptoms
- Adequate management of pain
- Live in a clean place
- Have meals that meet your needs and preferences
- Be listened to carefully and spoken to respectfully
- Have your own possessions and clothing as space permits
- Have your private space and belongings respected
- Receive notice before your room or your roommate is changed
- Share a room with your spouse if you both agree
- To return to the nursing home following a hospital stay

Your Right to Self-Determination

You have a right to -

- Participate in choices about food, activities, health care and other services based on needs, interests and the care plan

- Choose your physician
- Refuse treatment, including medication, dietary restrictions and experimental research
- Choose to do work for the nursing home or choose not to do work for the nursing home
- Be paid at the prevailing rate if you choose to work
- Associate with people you choose inside and outside the nursing home
- Participate in social, religious and other community activities
- Organize and participate in resident and family groups
- Have immediate visits by your personal physician, relatives, friends, ombudsman program and others providing health, social, legal or other services
- Exercise your rights granted as a citizen or resident of the United States, such as the right to vote

Your Right to Privacy & Information

You have a right to -

- Have information about you kept private

- Privacy during personal care, medical treatment and visits with family, friends and groups
- Send and receive mail unopened
- Use the phone privately without being overheard
- Privacy during visits with your spouse
- Be informed in language you understand of your health status, care and treatment and cost and any changes to the above
- Be fully informed of your care plan before it begins
- Access to all of your records within 24 hours after requesting them (excluding holidays and weekends) and have a copy of all or part of your records at a reasonable cost
- Give permission to family, friends or ombudsman to inspect records
- Information from nursing home on how to get help to pay for your care
- Information about your rights
- Examine results of the most recent survey conducted by state or federal licensing agents and plans of correction for licensing violations
- Written notice of all available services and their costs
- Receive a copy of the nursing home rules about resident care and conduct

Your Rights Regarding Your Finances

You have a right to -

- Manage your own finances
- Choose not to deposit your funds with the nursing home
- Choose to have the nursing home manage your funds
- If funds are managed by the nursing home, the home must:
 - Keep funds over \$50 in an interest bearing account
 - Keep your money separate from nursing home accounts
 - Keep and give you a written quarterly accounting of all transactions of your funds

Your Rights During a Nursing Home Transfer or Discharge

You have the right to:

- Remain in the facility unless –
 - It is not in your best interest
 - It is inappropriate for medical reasons
- To appeal the transfer or discharge

- Be safe during a transfer or discharge

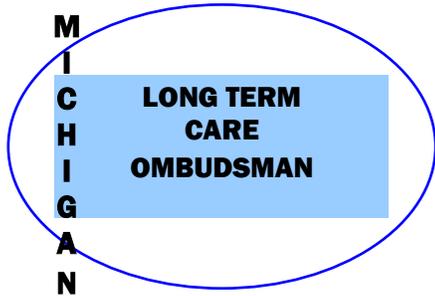
- Receive 30 days notice which states -
 - When the transfer or discharge will happen
 - Where you will be transferred or discharged to
 - Information on your right to appeal
 - The name, address and phone number of the State Long Term Care Ombudsman

Your Right to File Complaint

You have a right to voice your concerns without discrimination, reprisal or threat of discharge and receive a prompt response.

You can file a complaint using the nursing home complaint process. Call the Bureau of Health Systems (licensing) to file a complaint at: **1-800-882-6006**

In any case, you can call the Michigan Long Term Care Ombudsman Program for assistance at: **1-866-485-9393**



Fact Sheet

"Responsible Party" in a Nursing Home Contract

A nursing home is required to have a contract signed at the time a resident is admitted (and again if the source of payment changes).

Many homes will have a space at the end of the contract to for a **"responsible party"** to sign or co-sign. Whether it is permissible for a nursing home to require or suggest a third party sign the contract depends on how the contract defines "responsible party."

Under federal law, a nursing home cannot require a third party guarantee of payment as a condition of admission or continued stay. 42 USC 1396r(c)(5)(A)(iii). State law also has a provision prohibiting certain third party guarantees. MCL 333.21765a(2)(b).

These provisions mean a nursing home cannot require a spouse or child (or anyone else aside from the resident) to promise to use **her or his own money** to pay all or part of the nursing home bill.

Michigan law provides the **only** parties to a nursing home contract can be the nursing home on the one hand, and the resident or guardian or other legal representative authorized by law to have access to the resident's income or assets. MCL 333.21766(1).

A nursing home can thus require a court-appointed guardian or conservator, an attorney-in-fact under a durable power of attorney, or a trustee of a trust, to sign the contract, promising to use the **resident's** available funds to pay all or part of the nursing home bill.

If you are asked by a nursing home to guarantee payment for a resident using your own money, or if you question the legality of any other contract provision, please contact the State Long Term Care Ombudsman Program., toll-free, **1-866-485-9393**, before signing the contract.

MODEL MICHIGAN NURSING HOME RESIDENCY CONTRACT COVER SHEET

Bradley Geller
Roxanne Chang

A nursing home licensed in Michigan shall include the following language verbatim at the beginning of any contract for admission of a resident or continued stay of a resident.

These provisions are part of the contract, and no other provisions of the contract shall conflict with them. No contract provision shall conflict with federal or Michigan law.

Any provision of the written contract or any oral assurance in violation of these requirements is void. In addition, Michigan statute provides for criminal penalties and civil liability for a nursing home that violates the prohibitions below marked with an asterisk. MCL 333.21799c(1)(d).

1. The entire contract shall be in writing, using clear language and printed in at least 13-point type. MCL 333.21766(7).

*2. A nursing home shall not require an applicant, as a condition of admission, to waive his or her right to benefits under Medicare or Medicaid, to give oral or written assurance that the applicant is not eligible for Medicare or Medicaid, or to give oral or written assurance that the applicant will not apply for benefits under Medicare or Medicaid. MCL 333.21765a(1); 42 USC 1395i-3(c)(5)(A)(i); 42 USC 1396r(c)(5)(A)(i).

3. The only permissible parties to this contract are the nursing home, the resident, and any individual who has access to the resident's funds as an attorney-in-fact, trustee, representative payee, guardian or conservator. MCL 333.21766(1).

4. If an attorney-in-fact, trustee, representative payee, guardian or conservator signs the contract, she or he is only financially liable to the nursing home to the extent he or she has access to the resident's funds. MCL 333.21766(9); 42USC 1396r(c)(5)(B)(ii)

*5. The contract shall not require as a condition of an applicant's admission or a of a patient's continued residency that a person pay on behalf of an applicant or patient the private pay rate for a specified period of time before the applicant or patient applies for Medicaid. MCL 333.21765a(2)(b); 42 USC 1395i-3(c)(5)(A)(ii); 42 USC 1396r(c)(5)(A)(ii).

*6. The contract shall not require that an applicant or patient remain a private pay patient for a specified period of time before applying for Medicaid. MCL 333.21765a(2)(a).

*7. The contract shall not require that an applicant, patient, or other person make a gift or donation on behalf of that applicant or patient. MCL 333.21765a(2)(c).

8. In the case of an individual entitled to Medicaid, a nursing home shall not accept a gift or donation from anyone as a condition of an applicant's admission or expedited admission or a patient's continued stay. 42 USC 1396r(c)(5)(a)(iii).

9. A nursing home shall neither require nor request an applicant, resident or any

other person to disclose his or her income or assets, as a condition of admission of the applicant or continued residency.

10. A nursing home shall not require an application fee or a security deposit as a condition of admission of the applicant or continued stay of the resident, as it is a waiver, however short term, of the right to benefits under Medicaid.

11. The term of the contract shall be in bold type, in a conspicuous location. MCL 333.21766(8)(a).

12. The contract shall specify the certification of the bed into which the resident will move, and the number of beds in the facility that are dually certified for Medicare and Medicaid, certified only for Medicare, certified only for Medicaid, or licensed only.

13. The contract is terminated within the term of the contract in any of the following circumstances:

a. There is a change in the resident's source of payment, at which point a new contract shall be entered into consistent with these provisions. MCL 333.21766(1)(c); MCL 333.21766(2).

b. The nursing home discharges a resident without the resident's permission, if the discharge plan is approved by the Michigan Department of Community Health; the discharge is for a permissible reason under federal and state law; and the resident has exhausted any appeals she or she chooses to pursue.

c. The resident is transferred to a hospital and does not return to the nursing home from the hospital.

d. The death of the resident.

14. The contract can be terminated within the term of the contract in any of the following circumstances:

a. The resident provides 30 days notice to the nursing home.

b. The resident no longer meets the nursing home level of care.

c. Agreement between the parties to this contract.

15. Unless there is a change in the resident's source of payment, the contract is not terminated if a resident is admitted to a hospital and returns to the nursing home.

16. For a resident enrolled in Medicaid, a nursing home shall not require a person to pay the nursing home to hold a bed during a hospital stay.

17. During the term of the contract, a nursing shall not raise the daily rate for a resident paying privately.

18. At the end of the term of the contract, a nursing home can raise the daily rate for a resident paying privately only the amount it is raising the rate for all residents paying privately at the end of their respective contracts.

19. The contract does not provide a waiver of contract or tort liability of the resident, the nursing home, nursing home staff, or independent contractors of the nursing home.

20. The contract does not provide for mandatory arbitration of disputes between the nursing home and a resident.

21. The contract shall have all provisions required by Michigan law set forth in MCL 333.21766, including services covered by Medicare, Medicaid or the private pay rate, as applicable, and the cost of services available but not covered. MCL 333.21766(8)(b); MCL 333.21766(8)(c).

Individual authorized to sign on behalf of nursing home (please print)

Signature

Date

Applicant or resident (please print)

Signature

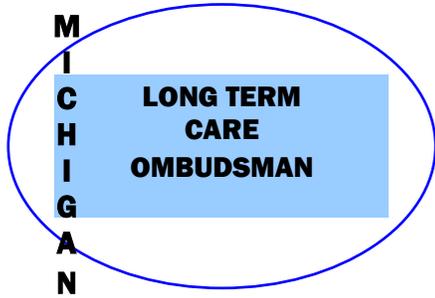
Date

Attorney-in-fact, trustee, representative payee, guardian or conservator (please print)

Signature

Date

**This form has not yet been approved by the Michigan Department of
Community Health pursuant to MCL 333.21766(7)**



Fact Sheet

Nursing Home Bed Certification

Each bed in a Michigan nursing home is classified by the state in one of four categories. These particular classifications are sought by the nursing home.

The different classifications determine what sources of payment the nursing home is permitted to accept for a resident occupying that particular bed.

(If Medicaid or Medicare is a permissible payment source, the resident would still have to qualify for payment from that particular program, and meet the level of care requirement for nursing home care.)

1. A bed can be **“dually certified”** for Medicare and Medicaid. In such case, the nursing home can accept Medicare, Medicaid, private payment (including private insurance) or charitable care for full or partial payment.
2. A bed can be certified as **“Medicaid only.”** The nursing home can accept Medicaid, private payment (including private insurance) or charitable care for full or partial payment.
3. A bed can be certified as **“Medicare only.”** The nursing home can accept Medicare, private payment (including private insurance) or charitable care for full or partial payment.

4. A bed can be “**licensed only.**” The nursing home can only accept private payment (including private insurance) or charitable care.

• • • •

The Michigan Department of Licensing and Regulatory Affairs maintains a list of all the state’s nursing homes, and identifies for each home how many of its beds are in each category. One home might have all its beds in one category; another home might have a number of beds in each of the four categories.

If one needs information on the certification of a PARTICULAR bed with a nursing home, one must contact the state licensing officer who services that geographical region. The licensing officer will have a “map” of each home, showing the certification of each bed.

Although the breakdown of beds and the map are public records, the public has no direct access to the information. It is not easy for residents or family to check the accuracy of representations made by a nursing home.

• • • •

A nursing home can request changes in bed certification from the Department of Licensing and Regulatory Affairs.

Assume an individual is in a licensed only or Medicare only bed, is paying privately, and has spent down his or her resources. Or Medicare has been paying for care, but the individual has used up his or Medicare days or no longer needs skilled care.

The nursing home can (if it so chooses) ask the Department to also certify that resident’s bed for Medicaid. The Department can expedite this process,

which would allow the individual to remain in that bed upon his or her qualification for Medicaid.

• • • •

State statute has long provided a nursing home has an obligation to obtain dual certification for a bed that is now Medicare only:

333.21718 Conditions of skilled nursing facility certification and participation in title 19 program; exception; exemption.

(1) Except as provided in subsections (3) and (4), as a condition of skilled nursing facility certification and participation in the title 19 program of the social security act, 42 U.S.C. 1396 to 1396k, a nursing home shall be concurrently certified for and give evidence of active participation in the title 18 program of the social security act, 42 U.S.C. 1395 to 1395qq. A nursing facility that is not concurrently certified for the title 18 program on the effective date of this section shall make application for concurrent certification not later than its next application for licensure and certification. A failure to make application shall result in the skilled nursing facility being decertified or refused certification as a provider in the title 19 program. Nursing home or nursing care facility participation in the title 18 program under the requirements for concurrent certification shall be effective not later than the beginning of the first accounting year following the home's or facility's title 18 certification.

(2) As a condition of skilled nursing facility certification, a nursing home shall obtain concurrent certification under title 19 of the social security act, 42 U.S.C. 1396 to 1396k, for each bed which is certified to provide skilled care under title 18 of the social security act, 42 U.S.C. 1395 to 1395qq. Skilled care certification shall not be renewed unless the requirements of this subsection are met.

(3) An exception may be made from the requirements of subsection (1) for a nursing facility that is currently certified as a skilled nursing facility by the director for title 19 participation but has been determined, after making application, to be ineligible for title 18 certification by the secretary of the United States department of health, education, and welfare.

(4) A home or facility, or a distinct part of a home or facility, certified by the director as a special mental retardation or special mental illness nursing home or nursing care facility shall be exempt from the requirements of subsection (1).

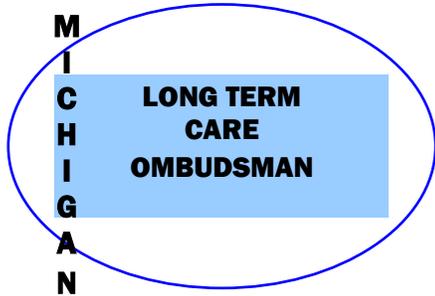
History: Add. 1978, Act 493, Effective Mar. 30, 1979 (emphasis added)

Various state departments over the years have opted not to enforce this law.

If a resident is threatened with involuntary transfer or discharge because of a change in source of payment from Medicare to Medicaid (that is, they are in a Medicare only bed), please contact the STLCO office. The Department of Community Health wishes to hear instances when residents are affected by the lack of dual certification.

• • • •

Caveat: Merely because a bed is certified in a certain manner creates no obligation on the part of a nursing home to accept a particular applicant. For instance, there might be a vacant bed that is dually certified. A nursing home can still deny admission to an applicant, so long as the home is not discriminating on a prohibited basis, such as the race of the applicant.



Fact Sheet

Reduction in Patient Pay

Patient pay is the amount a Medicaid beneficiary pays the nursing home each month. For a single individual, it is calculated by taking the individual's gross monthly income and subtracting health insurance premiums, the \$60 personal needs allowance, and guardianship fees (if applicable) not to exceed \$60.

For a married individual, the calculation may be more complicated, as the resident's spouse in the community may be entitled to part or most of the resident's income. The amount the community spouse is entitled to, if any, depends on the spouse's income and the spouse's housing expenses.

There are a number of circumstances in which a resident – single or married - may need to have his or her patient pay amount reduced, or has a right to a partial refund.

The following information is based on policies set forth by the Michigan Department of Community Health. It is important to realize that practice – by different DHS caseworkers and in different nursing homes – may not conform precisely to these policies. One should also be aware these processes can be painfully slow, and are subject to change.

1. The resident or community spouse suffers a reduction in income, such as a cut in pension benefits.

The resident or someone on his or her behalf must present proof of the change in income to the resident's caseworker at the local office of the Michigan Department of Human Services. The caseworker enters the information into the system, and the resident should receive notice of any adjustment to his or her patient pay amount.

2. The resident purchases health insurance, or the premiums for an existing health insurance policy increase.

The resident or someone on his or her behalf must present proof of the change in premium or insured status to the resident's caseworker at the local office of the Michigan Department of Human Services. The caseworker enters the information into the system, and the resident should receive notice of any adjustment to his or her patient pay amount.

3. The resident's income is reduced as a result of a court order such as child support, a federal or state tax lien, or a recoupment by the Social Security Administration or other federal agency.

The resident (or someone on her of his behalf) contacts the DHS caseworker, presenting documentary proof of the reduced income. The caseworker then submits a "policy exception request" to the Program Policy Division, Eligibility Policy Section of the Michigan Department of Community Health in Lansing, PO Box 30479, Lansing, Michigan 48909.

(If a caseworker is unaware of this procedure, you may refer them to the Bridges Eligibility Manual [BEM] Item 100, pages 7-9. If a caseworker refuses to process the request, contact the State Long Term Care Ombudsman.)

The Eligibility Policy Section will make a decision, complete form DHS/DCH-1785, and send the form to the local caseworker. If the decision is to grant the exception, the caseworker will implement it, reducing the resident's

patient pay amount until the child support ceases or the lien or recoupment is satisfied.

4. The resident has unpaid medical bills dating from before she or he was eligible for Medicaid.

Federal law provides these expenses must be covered, though the state can set reasonable limitations. There was federal litigation when Michigan refused to honor the federal mandate; Michigan now complies.

The resident or family should follow the procedure set forth in Paragraph 3, above.

5. The resident needs medical services not covered by Medicaid, such as eyeglasses.

Under federal law, the resident has the right by law to a reduction in patient pay amount for present medical needs not covered by Medicaid.

The resident uses present income to pay for the medical need, and subtracts the cost from her or his patient pay. The resident provides documentation of the expense to the nursing home.

The nursing home will show the amount of the reduced patient pay on the UB-92 form the nursing home submits to the state for that month.

If the nursing home has an issue with the expense, the appropriateness of the charge will be determined by a facility analyst at the Department of Community Health. (Bridges Eligibility Manual [BEM] Item 546, p. 9.)

6. The resident has just enrolled in Medicaid, and the resident's physician believes the individual will be able to return home within 6 months.

The resident must provide certification (a letter) from his or her doctor stating that the resident is likely able to return home within 6 months. (The doctor must clearly state it is likely – not just possible – the resident can return home.) The doctor should include in her or his letter the date the resident entered the nursing home.

The resident must also provide xerox copies of his or housing expenses, such as utility bills, telephone bill, homeowners or renters insurance, mortgage or rent payments, and property tax expenses. The usual maximum amount allowed is \$698.00 per month, but that can be increased upon request.

Third, the resident must complete a simple form, DCH-1183.

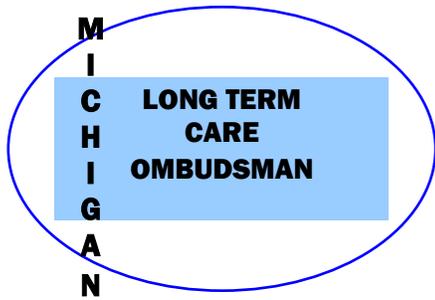
Finally, the residents need to write a cover letter that merely requests a "Special Director's Exception."

All these documents should be mailed or faxed together. The fax number is (517) 241-8969. The mailing address is

Special Director's Exception Request
Eligibility Policy Center
PO Box 30479
Lansing, MI 48909

7. The resident dies or leaves the nursing home during the first part of a month.

If a resident dies or leaves in the first part of a month, she or he may be entitled to a partial refund. To determine this, the nursing home takes the patient pay amount and subtracts from it its per diem Medicaid rate times the number of days the resident was in the facility. If there is a positive balance, the nursing home must refund it.



Fact Sheet

Therapeutic Leave Days

Under Michigan law, a resident of a nursing home can leave the home for a number of days for non-medical reasons, then return:

If a patient is temporarily absent for therapeutic reasons as approved by a physician, the nursing home shall hold the bed open for 18 days, if there is a reasonable expectation that the patient will return within that period of time and the nursing home receives payment for each day during the absent period. Temporary absences for therapeutic reasons are limited to 18 days per year." MCL 333.21777(2).

There is some ambiguity in the statute, as there is no definition of "therapeutic reasons, and no definition of "per year." It might also appear the statute allows only for one continuous absence.

The first two issues are clarified in the "Michigan State Plan Under Title XIX of the Social Security Act" (a.k.a State Medicaid Plan).

The relevant section of the State Medicaid Plan is entitled "Payment for Reserved Beds During a Patient's Absence from an Inpatient Facility." Section II, in part:

- A. Therapeutic Leave Days - payment is subject to the following conditions:

1. The [Medicaid] beneficiary is away for therapeutic and non-medical reasons (for example, home visits).

2. Payment for reserving a bed for a beneficiary's therapeutic leave days may not exceed payments for 18 days over the most recent 12-month period.

...

5. The beneficiary's written plan of care provides for 'home visits' (defined as visits with friends and/or relatives, i.e., therapeutic leave days).

Thus, a therapeutic leave must be for non-medical reasons, and the 18-day limitation is based on the prior 365-day period, and not a calendar year.

The third issue is clarified in the Medicaid Provider Manual, in Section 11.2.B. It reads, in part:

There is no limit to the number of therapeutic leave days that may be reimbursed at one time as long as the total does not exceed 18 days in a 365 day period (not the calendar year). For example, if a resident goes on a 5-day family vacation beginning November 9, 2010, that resident has 13 therapeutic leave days remaining until November 8, 2011.

Thus, an individual could take one 18-day leave, or 18 one-day leaves, or any other combination of 18 days.

The Medicaid Provider Manual also (implicitly) indicates the term "therapeutic leave days" is a misnomer:

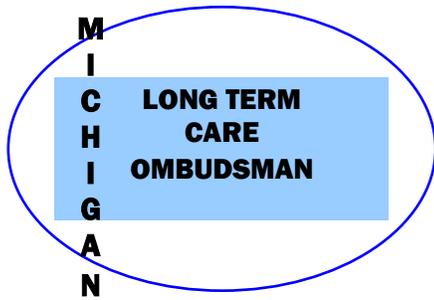
A resident is counted in the facility census if they (sic) are in the facility at midnight. If the beneficiary is out of the facility on therapeutic leave at midnight, that day must be counted as a therapeutic leave day.

So, the allowance is really for "therapeutic leave nights."

If a resident left a nursing home for therapeutic leave on Tuesday at 7 a.m., and returned on Wednesday at 11:00 p.m., that would constitute one leave day, not two.

A resident could leave a nursing home at 7 a.m. and return the same day at 11:00 p.m., without using a therapeutic leave day. The resident would not need physician approval, and the absence could be for any reason, e.g., a medical appointment.

The State Plan allows for additional leave days beyond 18 days for "special family occasions (e.g., reunions, weddings, graduations, birthdays, religious rites.)" These additional days require "prior authorization" (presumably from the Department of Community Health).



Memorandum

Day Leaves

An issue has arisen several times about the right of a resident to leave the nursing home for a period of time during the day.

The issue seems not to arise if the resident is picked up at the nursing home by family or friends and taken out to lunch, or to a medical appointment, or for church, or for a family occasion. There also is no problem if staff accompanying a resident or residents, e.g., to a medical appointment or for an outing.

If the individual will be gone past midnight, this would constitute a therapeutic leave day, and a physician must approve the leave.

What if a resident wishes to leave the nursing home to (by him or herself, or with another resident) to go to the corner store to buy a pop, or to take a walk, or to attend a ball game? Can a nursing home prohibit this in some circumstances? Require the attending physician's approval? Put a limit on the length of leave, time of day, weather conditions or purpose of the trip? Allow travel by foot or wheelchair but not public transportation? Demand the resident sign out and provide the planned destination?

In making these decisions, a nursing home may be influenced by its view of the safety of the resident, fear of being cited or fear of civil liability for negligence.

After searching federal and state statute, regulations and policy, and speaking with state regulators, I could find no answer.

A resident - assuming he or she has no guardian - has a clear right to leave a nursing home for good. This is so even if staff and the doctor disagree with the decision. A nursing home would be liable were it to prevent a resident from leaving.

Federal does have broad provisions which could be a basis for a right to leave during the day. These include rights to "self-determination," 42 CFR 483.10, and "dignity," 42 CFR 483.15; to "choose activities," 42 CFR 483.15(b)(1); to "interact with members of the community both inside and outside the facility, 42 CFR 483.15(b)(2); to "participate in social, religious and community activities," 42 CFR 483.15(d); and to "make choices about his or her life in the facility that are significant to the resident." 42 CFR 483.15(b)(3).

State law provides the parameters for therapeutic leave.

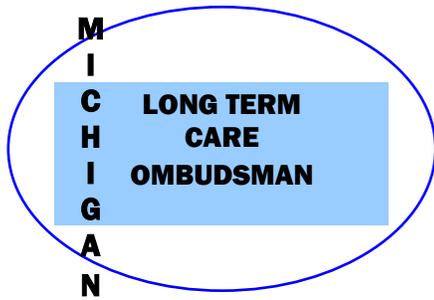
Perhaps the issue of day leaves is not explicitly addressed because the right to interact with members of the community and to participate in community activities presumes that right.

And perhaps the issue of day leaves arises more today than when these laws were written 30 years ago. Some residents have fewer health needs; perhaps an increased number are ambulatory. There are younger residents who may demand greater freedom. More beds may be filled with "patients" rather than "residents," i.e., individuals in the home for short-term rehabilitation.

This view was articulated well by a licensing officer when I sought guidance. She replied, "If the resident is able to leave the nursing home by herself, why is the resident in a nursing home?"

A strong argument can be made that a nursing home cannot have a blanket policy prohibiting day leaves. On the other hand, a nursing home certainly could (and must) prevent a resident dressed only in a nightgown from walking out of the home at 3:00 a.m., into a blizzard.

In between, there is room for advocacy.



Fact Sheet

Protection of Personal Property

Problem

Martha Washington is a resident of Gates Nursing Home. She owns a laptop computer, which disappears from her room. Ms. Washington is certain it was stolen, since she never takes her laptop from her room.

Resident seeks recompense from the nursing home. The administrator, Steve Jobs, denies the claim citing a waiver of liability form Ms. Washington signed at admission.

Analysis

A. Federal law - personal property

Federal regulations provide a resident has the right to retain and use personal possessions, including some furnishings and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents." 42 CFR 483.10(L).

None of the exclusions apply to a laptop, as it is small and neither presents a danger nor impinges on the rights of other residents.

“Environment. The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.” 42 CFR 483.15(h)(1).

Federal regulations further provide a "facility must develop and implement written policies and procedures that prohibit ... misappropriation of resident property." 42 CFR 483.13 (c).

The facility must report and thoroughly investigate alleged incidents of misappropriation of personal property and "if alleged violation is verified appropriate corrective action must be taken." 42 CFR 483.13(c)(2), (3) and (4).

In the present case, we do not have information whether the nursing home reported and investigated the loss of the resident's laptop.

B. Federal policy

Surveyor's guidelines expand upon the issue of personal property.

Tag F174

...

Sec. 483.10(L) Personal Property

...

Intent: The intent of this regulation is to encourage residents to bring personal possessions into the facility, as space, safety considerations and fire code permits.

Interpretive Guidelines: All residents' possessions, regardless of their apparent value to others, must be treated with respect, for what they are and what they may represent to the resident. The right to retain and use personal possessions assures that the residents' environment be as homelike as possible and that residents retain as much control over their lives as possible. The facility has the right to limit the resident's exercise of this right on ground of space and health or safety."

Procedures: If residents' rooms have few personal possessions, ask residents, families and the local ombudsman if:

Residents are encouraged to have and use them;

The facility informs residents not to bring in certain items and for what reason; and

Personal property is safe in the facility.

Ask staff if the facility sets limits on the value of the property that residents may have in their possession or requires that residents put personal property in the facility's safe.

A fair reading of this language is that a nursing facility cannot limit possession of items based merely on the item's value.

C. State law - personal property

A nursing home patient or home for the aged resident is entitled to retain and use personal clothing and possessions as space permits ... MCL 333.20201(3)(c)

D. State law - other rights

Each nursing home patient may associate and communicate privately with persons of his or her own choice MCL 333.20201(3)(b).

A patient or resident is entitled to associate and have private communications and consultations with his or her physician, attorney, or any other person of his or her own choice

A patient or resident is entitled to his or her rights as a patient or resident and as a citizen, and to this end may present grievances or recommend changes in policies or services on behalf of himself or herself or others to the health facility or agency staff, to government officials, or to another person of his or her choice within or outside the health facility or agency. free of restraint, interference MCL 333.20201(2)(g)

A patient's or resident's civil and religious liberties, including the right to independent personal decisions and the right to knowledge of available choices, shall not be infringed and the health facility or agency shall encourage or assist in the fullest possible exercise of these rights. MCL 333.20201(2)(k).

A nursing home patient or home for the aged resident is entitled to the opportunity to participate in the planning of his or her treatmentMCL 333.20201(3)d)

Access to the web could provide a resident knowledge of available choices, including options for medical treatment and for transition to the community.

... A patient or resident may meet with, and participate in, activities of social, religious, and community groups at his or her discretion" MCL 333.20201(2)(k)

E. Policy of nursing home

State law provides a nursing home patient "is entitled to be fully informed, as evidenced by the patient's ... written acknowledgement ... of the policy required by this section [MCL 333.20201]"

Gates Nursing Home complies with this requirement by giving each resident upon admission of a document entitled, "GATES NURSING HOME - RESIDENT RIGHTS AND RESPONSIBILITIES." Ms. Washington received this document.

The document reads, in part,

Residents will be entitled to maintenance and use of their own personal clothing and possessions (other than valuables) as space permits ...

Each resident will be advised prior to, or at the time of admission, as to items that may be brought into the facility and whether or not the will accept responsibility for those items.

Ms. Gates was given an additional document entitled, "PLEASE DO NOT BRING." The list includes medications, credit cards, bank-books, check books, large amounts of cash, expensive jewelry, cell phones and alcoholic beverages. The list provides electric razors must be properly stored at the nursing station to prevent loss.

The list does not mention television sets, radios, CD or DVD players. The list does not mention desktop or laptop computers.

From its own policy, the nursing home does not even suggest a resident not have a laptop computer.

F. Waiver signed by resident

Upon admission, Ms. Washington signed a document provided by Gates Nursing Home entitled, "WAIVER REGARDING VALUABLES."

The document states, in part,

I (we) have been advised that gates Nursing Home will not be responsible for lost or misplaced items such as jewelry left in a resident's room ...

I (we) understand that Gates Nursing Home will not replace or compensate a resident ... for lost or misplaced valuables left with a resident or in a resident's room.

1. The document helps explain the definition of the term "valuables" used in the facility policy discussed above. A laptop computer is not an item "such as cash and jewelry." and a computer is not among the items on the "Please Don't Bring List." Thus the waiver does not apply.

2. The waiver refers to valuables "lost or misplaced." Ms. Washington is not claiming she lost or misplaced her laptop, but that it was stolen. While "lost" can have a broader meaning, it should be strictly interpreted due to paragraph 3, below.

3. Courts look askance at attempts to contractually avoid tort liability. This is particularly so when the parties to a contract have unequal bargaining power, as do a resident and a nursing home. [Depending on circumstances, tort liability can be based on a standard of negligence, gross negligence, willful and wanton conduct, intentional act, *res ipsa loquitar*, or strict liability.]

A likely suspect for the theft is a staff member. The nursing home certainly has a duty to try and prevent such thefts. Arguably, a theft of personal property is a breach of that duty, i.e., negligence.

4. Finally, given the importance given in law for a nursing home resident to maintain personal property, a court might inquire who is in a better position to insure against such loss. Surely the nursing home can more easily purchase insurance.

So even if the waiver applied to a stolen computer, a court might find the waiver unenforceable as contrary to public policy.

Conclusion

Federal law and policy provide for protection of personal property and encouragement of its use. The law sets forth a duty of homes to prevent thefts by staff. Policy implies a nursing home cannot limit personal property merely based on its value. A computer can be helpful - and possibly necessary - to a resident exercising other federally protected rights.

Several Federal provisions are echoed in Michigan law. State law also includes rights implicated by the loss of a communication device.

Under federal law, a nursing home has a responsibility to investigate and report the loss of property and if an allegation is verified, to take appropriate corrective action.

Gates Nursing Home policy and waiver by their terms apply to money and jewelry and not a computer. The waiver applies if a resident loses or misplaces property, not if it is stolen. The policy and waiver may run afoul of federal policy prohibiting a nursing home from excluding personal property based on its value. Finally, the waiver may well be otherwise unenforceable.

In the present case, appropriate action would be for the nursing home to replace Ms. Washington's laptop computer with a comparable one, or to provide her funds to make such purchase. In addition, the nursing home must take steps to prevent thefts.

Fact Sheet

Involuntary Transfer or Discharge from a Nursing Home

What is an involuntary transfer or discharge?

An involuntary transfer or discharge occurs when a resident is required to leave the nursing home without the option of returning, regardless of his or her destination.

A transfer or discharge should not be considered voluntary unless the resident or his or her legal representative freely agree to it in writing.

Under what circumstances can a nursing home discharge a resident involuntarily?

State and federal law protect residents from involuntary discharges except in limited circumstances. A nursing home may discharge a resident **only** for the following reasons:

- The resident's welfare cannot be met in the facility
- The resident's health has improved sufficiently and the resident no longer needs the services of the facility

- The safety or health of individuals in the facility is endangered.
- The resident has failed to pay monthly charges (either directly or through Medicaid or Medicare) and no Medicaid application is pending or on appeal
- The facility, itself, closes voluntarily or involuntarily

The law **does not** permit a facility to involuntarily transfer or discharge a resident merely because -

- The resident or his or her family is difficult or unpleasant
- The resident or his or family complains about the facility
- The resident requires needs a high level of care, supervision, or assistance
- The resident's payment source changes from private pay or Medicare to Medicaid as long as a Medicaid certified bed is available in the facility.

In many nursing homes, all beds are certified for Medicaid. If a facility claims it does not have a Medicaid bed available, check with the ombudsman or with the Bureau of Health Systems in the Michigan Department of Community Health to verify the facility's statement.

What rights do residents have when a facility attempts to discharge them without their consent?

1. Written notice

The nursing home must provide the resident written notice in a language the resident or the resident's representative can understand. The notice must also be provided to an immediate family member or legal representative, if known.

Facilities must use a form developed by the Michigan Department of Community Health that includes the reason for the transfer or discharge, the date of the proposed transfer or discharge, and the location to which the person will be transferred or discharged. The notice must also include a hearing request form and a postage-paid, pre-addressed envelope to the Department.

Written notice must be given at least 30 days before the proposed transfer or discharge in most cases. In the limited circumstances described below, written notice may be given less than thirty days prior to the transfer or discharge:

- A more immediate transfer is necessary because of the resident's urgent medical needs
- The transfer or discharge is based on an allegation that the resident is a danger to the health or safety of others. This is **only** legitimate if the resident presents an immediate, substantial danger to others. Moreover, the nursing home should have documented the danger and attempts to address the issues that gave rise to the dangerous situation.
- The resident's health has improved sufficiently to allow a more immediate transfer or discharge.

2. Preparation for transfer or discharge

It is the facility's legal responsibility to find an appropriate location to which to discharge the resident **and** to provide sufficient orientation and preparation to minimize harm from the move. Facilities cannot put the burden of finding an alternate placement on the resident or family member and may not require the family member to take the resident home if the family member does not wish to or is not able to do so. Among the tasks the nursing home is required to do are -

- Discuss the transfer or discharge with the resident, the resident's next of kin or guardian or the person or agency responsible for the resident's placement or care in the facility
- Summarize the discussion and who was present in the resident's clinical record
- Provide counseling before and after the discharge to minimize emotional trauma
- If at all possible, arrange for the resident to visit the place to which he or she will be discharged
- Under Michigan law, facilities should also consider the recommendation of the attending physician, make the optimum placement to minimize the possibility of subsequent transfers, involve the resident and his or her family and/or guardian in the process of choosing a new home, and ensure a family member or other appropriate person is available to accompany the resident when he or she moves (unless the resident declines to be accompanied).

3. Approval by BHS

Before a resident can be transferred or discharged, the facility must submit documentation of the discharge plan to the Michigan Department of Licensing and Regulatory Affairs, and the discharge plan must be approved by the Bureau of Health Systems within the Michigan Department of Licensing and Regulatory Affairs.

4. Appeal

A resident has the right to appeal the transfer or discharge by requesting a hearing. Requests for hearings to appeal the discharge (using the form provided or any written communication) must be sent within 10 days after receipt of the written notice to:

Michigan Department of Licensing and Regulatory Affairs
Bureau of Health Systems, Division of Operations
Complaint Investigation Unit
P. O. Box 30664
Lansing, Michigan 48909

The resident can stay in the facility (and Medicaid will continue to pay if that is the resident's source of payment) while the appeal is pending. Hearings are conducted by an Administrative Law Judge at the facility and the burden of proving the discharge is permissible rests on the nursing home. Residents or their representatives can present information and witnesses to demonstrate that the discharge is inappropriate or that the nursing home failed to fulfill its legal responsibilities.

If the resident loses the hearing, he or she must leave the facility the 34th day following receipt of the written notice or the 10th day following receipt of the

Administrative Law Judge's decision, whichever is later, as long as there is an acceptable discharge plan.

5. Rehearing and/or Court Suit

If the discharge is upheld by the Administrative Law Judge, the resident has a right to request a rehearing or bring suit in Circuit Court in the county where the nursing home is located.

For assistance or further information regarding involuntary discharges, please contact the State Long Term Care Ombudsman Program, toll free, **1-866-485-9393**.

**Michigan Department of Licensing and Regulatory Affairs
Bureau of Health Systems**

**APPEAL OF A NOTICE OF AN INVOLUNTARY TRANSFER OR
DISCHARGE**

I hereby appeal and request a hearing due to a *Notice of Involuntary Transfer or Discharge* from this facility or a distinct part of the facility.

Return completed form to:

Michigan Department of Licensing and Regulatory Affairs Bureau of Health Systems, Division of Operations Complaint Investigation Unit P.O. Box 30664 Lansing, Michigan 48909 (Street Address: 611 W. Ottawa Street; Lansing, Michigan 48933)

If you have any questions regarding this procedure you may call the Involuntary Transfer Coordinator with the Division of Operations at (517) 241-4712 or send a fax to (517) 241-0093 for assistance.

(Please print or type)

Person Requesting Appeal _____

Street Address of Person Appealing _____

City _____ State _____ Zip Code _____

Daytime Telephone _____

Name of Resident _____

Facility Name _____

Facility Street Address _____

City _____ State _____ Zip Code _____

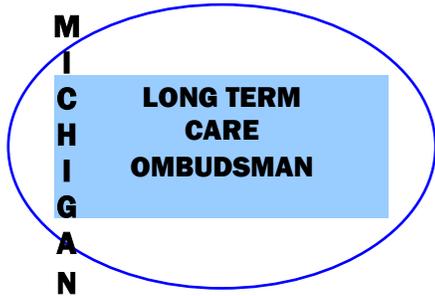
Date Notice Received _____

Signature of Person Requesting Appeal _____

Date (must be within 10 days of receipt of notice) _____

Relationship to Resident

Resident Durable Power of Attorney Guardian Other (explain)



Fact Sheet

Improper Justifications for Discharge from a Nursing Home

Alison Hirschel

A. Resident is disruptive.

No discharge unless resident is a danger to himself or others. Since a high percentage of residents have dementia or mental illness, disruptive behavior is not unusual and facility staff are supposed to be trained to respond to difficult behaviors.

B. Resident is argumentative and/or obnoxious.

Being argumentative does not rise to the level of being a danger to oneself or others. Facility staff are supposed to be trained to difficult behaviors. Is the facility failing to accommodate the resident's needs as required by law and is that failure the cause of the resident's alleged argumentative or obnoxious behavior.

C. Resident does not follow facility policies

Unless failure to follow policies creates a danger to the resident or others (e.g., not following a nonsmoking policy, especially around oxygen), this is not a legitimate reason for discharge. Facility has to accommodate resident's individual needs and preferences regardless of facility policies that may conflict with resident's choices. If the admissions contract requires residents to abide by facility policies or face discharge, the contract

provision should be unenforceable if the circumstances in the contract extend beyond allowable reasons for discharge in law.

D. Resident has injured staff members

If the injury to the staff is relatively minor, discharge is not appropriate. Aggressive behavior is not an uncommon manifestation of dementia and mental illness, and staff are supposed to be trained to handle it. If the injury is more significant, it is unlikely the resident can successfully defend against an involuntary discharge. Advocates may argue behavior resulted from facility's failure to do care planning and provide appropriate treatment to address and reduce aggressive behaviors and that the "danger to oneself or others" applies primarily to residents posing a danger to other residents, not staff, but these arguments are unlikely to be successful if resident has caused serious injury.

E. Resident has refused treatment

Residents, like anyone else, retain their constitutional and common law right to refuse treatment. The right is specifically set forth in the Nursing Home Reform Law. 42 U.S.C. §§ 1395i-3(c)(1)(A)(I)' 1396r(c)(1)(A)(I), 42 CFR §483.10(b)(4).

F. Caring for resident is too burdensome and/or expensive.

This is not one of the specified legitimate reasons for discharge. If the care of the resident is exceedingly expensive, the facility may apply for a Memorandum of Understanding from the Department of Community Health for a higher per diem rate (granted for residents on ventilators and in limited other situations).

G. Facility is exposed for potential legal liability for injuries suffered or caused by resident.

This is not one of the specified legitimate reasons for discharge.

H. Resident does not need facility's specialized services.

Nursing facilities are licensed as nursing facilities, not as a range of specialized facilities. Even if facilities choose to specialize in certain types of care, as long as the resident continues to qualify for nursing facility level of care, the facility must continue to meet his or her needs.

I. Medicaid has ruled that resident does not need nursing facility care.

Even if the resident fails to qualify in the Level of Care Determination process, the facility must follow all steps required for an involuntary discharge; the failed Level of Care determination does not provide a short-cut for dumping residents. Residents should appeal both the level of care determination and the discharge.

J. Resident's Medicaid application is in process; facility has not been paid.

See MCL 333.21773(6): If the basis for an involuntary transfer or discharge is the result of a negative action by the Department of Licensing and Regulatory Affairs, and a hearing request is filed with the department, the 21-day written notice period [note: this should have been changed to a 30 day notice period to be consistent with section 2 of this statute and federal law] does not begin until a final decision is rendered by the Department of Licensing and Regulatory Affairs or a court, and notice of that final decision is received by resident and nursing home. See also: "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." Surveyor's Guideline to 42 C.F.R. § 483.12.

However, it is unclear if the facility has to delay discharge until all appeals have been completed, though a reasonable argument can be made for the resident in this situation. If the facility failed to assist the resident in applying in Medicaid or did something that contributed to the denial that should be emphasized as a defense.

K. Resident has exhausted savings; now is Medicaid-eligible.

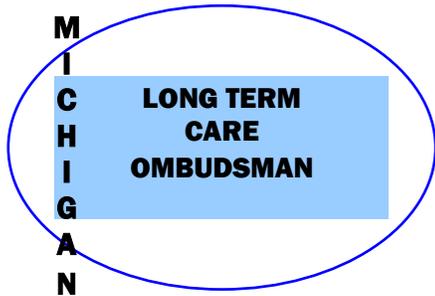
If the facility is Medicaid certified (and, in the case of facilities partially certified, has a Medicaid bed available), discharge is not permitted. Federal law prohibits discrimination on the basis of payment source and the Surveyor's Guidelines emphasize that conversion to Medicaid does not constitute nonpayment. See 42 USC §§ 1395i-3(c)(4); 1396r(c)(4)(A); 42 CFR § 483.12(c)(1).

L. Facility has voluntarily withdrawn from Medicaid program.

If a resident enters a facility when it is Medicaid-certified, that resident is always permitted to remain in the facility as a Medicaid recipient if and when he or she qualifies for Medicaid even if the facility has pulled out of Medicaid at some time after the resident's admission. The facility will continue to be Medicaid certified with respect to residents who entered the facility prior to its voluntary withdrawal from Medicaid until the last of those residents leaves the facility. See MCL 333.21773(10) and 42 USC §1396r(c)(2)(F).

M. Facility is part of hospital complex.

If the facility is certified as a nursing facility for Medicaid or Medicare or licensed as a nursing home in the state, it must provide nursing facility services.



Fact Sheet

Staffing Requirements In Nursing Homes

One of the most frequently expressed concerns about nursing homes involves lack of adequate staff. This is a summary of Michigan and federal staffing requirements in nursing homes.

Administrator: A nursing home must be run by a licensed administrator. The administrator must work at a single home full-time if the facility has 50 or more beds.

Medical Director: Nursing homes that participate in Medicare or Medicaid must designate a physician to serve as medical director. The medical director is responsible for coordinating medical care within the facility and establishing policies and procedures regarding medical care. The medical director may or may not also serve as the attending physician for some residents in the facility.

Attending Physician: Each resident must have a physician in charge of overall medical treatment. The resident has the right to choose an attending physician.

Director of Nursing: Each nursing home must have a registered nurse (RN) employed full-time as Director of Nursing (DON). The DON must have specialized training or relevant experience in the area of gerontology and is responsible for managing the nursing services of the facility.

Registered Nurses: A Medicare- or Medicaid-approved nursing home must have at least one registered nurse on duty at least eight consecutive hours per day, seven days a week.

Charge Nurses: Each nursing home must have a licensed nurse (RN or Licensed Practical Nurse) on each shift to serve as charge nurse. The charge nurse is responsible for the immediate direction and supervision of nursing care provided to residents. In homes with 30 (60?) or more beds, the director of nursing cannot serve as charge nurse.

Ratio of Licensed Nurses to Residents: A certified skilled nursing facility must have at least one licensed nurse for each 64 residents on the day shift, one licensed nurse for each 96 residents on the afternoon shift, and at least one licensed nurse for each 120 residents on the night shift. Additional licensed nurses are required if needed to meet resident care needs.

Nurses Aides and Orderlies: In most nursing homes, unlicensed aides and orderlies provide the majority of personal care needed by residents. Aides and orderlies who provide direct care to residents are counted in determining if the minimum staffing requirements are met.

Staff to Resident Ratios: Michigan nursing homes must have a sufficient licensed and unlicensed nursing staff to provide an average of at least 2.25 hours of nursing care per resident per day. In addition, nursing homes must meet the following ratios of nursing staff members to residents:

Day Shift: 1 nursing care employee per 8 residents

Afternoon Shift: 1 nursing care employee per 12 residents

Night Shift: 1 nursing care employee per 15 residents

These ratios must be met on a facility-wide basis. Licensed nurses, aides and orderlies are all counted/n determining if the above ratios are met. The Director of Nursing is not counted in nursing homes with 30 or more beds.

General Requirements for Nursing Staff: Even if it requires staffing levels above the minimum ratios, nursing homes are required to have a sufficient nursing staff to meet the needs of each resident in the nursing home and to assure coverage for residents at all times during each shift.

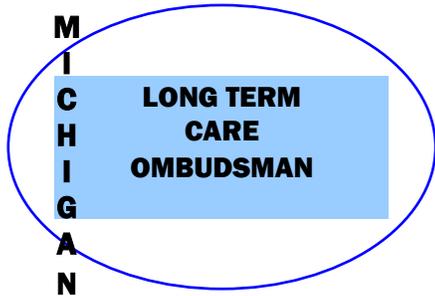
Nursing Responsibilities: An employee designated as a member of the nursing staff shall not be involved in providing basic services such as food preparation, housekeeping, laundry or maintenance services, except in the event of an emergency.

Social Work Staff: Medicare- and Medicaid-certified nursing homes must have a qualified social worker. Facilities with more than 120 beds must have a full-time social worker with a bachelor's degree in social work or a bachelor's degree in a human services field plus one year of social work experience in a health care setting.

Dietary Staff: The nursing home must have a dietary or food service supervisor who meets State training requirements. If the food services supervisor is not a registered dietician, the supervisor must receive at least four hours supervision from a registered dietician each 60 days. Sufficient numbers of other food service personnel must be employed to meet dietary requirements and to provide staffing at least 12 hours per day.

Activities Staff: All nursing homes must have at least one qualified person designated to plan and carry out activities with residents. Additional staff members must be employed as needed to provide a stimulating activity program, seven days a week.

Other Staff: Nursing homes must employ qualified staff members to carry out other responsibilities such as housekeeping, business management, admissions and security. Nursing homes must also ensure that residents receive needed medical services from qualified professionals, such as doctors, dentists, therapists, and radiologists. Often, these medical professionals are not regular employees of the home but may work for the facility under contract or some less official arrangement.



Fact Sheet

Required Postings in Nursing Homes

Advocacy Groups

A posting of names, addresses and telephone numbers of all pertinent State client advocacy groups, such as -

- State Survey and Certification Agency
- State Licensure Office
- State Long Term Care Ombudsman Program
- Protection & Advocacy Network
- Medicaid Fraud Control Unit

42 CFR 483.10(b)(7)(iii)

Staffing

Posted daily for each shift, the numbers of licensed and unlicensed nursing staff (R.N., L.P.N., Licensed Vocational Nurses and Certified Nursing Assistants) directly responsible for resident care.

- Current staffing – FTEs for each shift, licensed and unlicensed
- Current resident census
- Displayed in prominent place readily accessible to residents and visitors

Medicare – Sec 1819(b), 42 U.S.C. 1395i – 3(b)

Facility Complaint Procedure

- The nursing home must have complaint forms available without having to ask a staff person. If the resident needs help filling out the form, someone needs to be available to assist them.
- Posting of Contact Person on duty to receive complaints
 - Contact Person Name and Telephone Number
 - Location in Nursing Home
 - Contact Person available 24 hrs/day, 7 days/week

Michigan Public Health Code, MCL 333.21723

Inspection/Survey Reports – Statement of Deficiencies

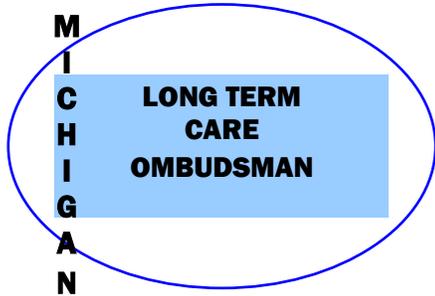
The nursing home must make the results of the most recent survey (and any subsequent extended surveys and any deficiencies resulting from any subsequent complaint investigations) available for examination in a place readily accessible to residents, such as a lobby or other area frequented by most residents. The survey results should be available in readable form (binder, large print, or provided with magnifying glass) and are available without having to ask a staff person.

HCFA 2567; 42 CFR 483.10(g)(1)

Medicare and Medicaid Benefits

The nursing home must prominently display information about how to apply for and use Medicare and Medicaid Benefits.

42 CFR 483.10(b)(10)



Fact Sheet

Special Diets for Nursing Home Residents

1. What must a nursing home provide?

Federal and state law and regulation require a nursing home to provide special diets to residents who need them.

A. Federal statute

To the extent needed to fulfill all plans of care ... a skilled nursing facility must provide

(iv) dietary services that assure that the meals meet the daily and special dietary needs of each resident

42 USC 1395i-3(b)(4)(A)(iv). This section relates to Medicare. Essentially the same language is found in 42 USC 1396r(b)(4)(A)(iv), relating to Medicaid.

B. Federal regulation

Based on a resident's comprehensive assessment, the facility must ensure that a resident

(2) Receives a therapeutic diet when there is a nutritional problem.

42 CFR 483.25 (i)(2)

The facility must provide each resident with a nourishing, palatable, well balanced diet that meets the daily nutritional and special dietary needs of each resident.

42 CFR 483.35

C. Federal Guidance to Surveyors

F Tag 360

2. What is a therapeutic diet?

A. Federal Guidance to Surveyors

"Therapeutic Diet" is defined as a diet ordered by a physician as part of a treatment for a disease or clinical condition, or to eliminate or decrease certain nutrients in the diet (e.g., sodium) or to increase specific nutrients in the diet (e.g., potassium) or to provide food the resident is able to eat (e.g., a mechanically altered diet).

"Mechanically altered diet is one in which the texture of a diet is altered. When the texture is modified, the type of texture modification must be specific and part of the physician's order.

F Tag 376

3. Who has authority to order a special diet?

A. Federal regulation

Therapeutic diets must be prescribed by the attending physician.

42 CFR 483.35(e)

B. State rule

Therapeutic diets shall be provided upon written prescription or order of the physician.

Michigan Administrative Code R 325.20803(3)

4. Who must supervise provision of a special diet?

A. Federal statute

Services described ... must be provided by qualified persons in accordance with each resident's plan of care.

42 USC 1395i-3(b)(4)(B); 42 USC 1396r(b)(4)(B)

B. Federal regulation

The facility must employ a qualified dietitian either full time, part time or on a consultant basis.

42 CFR 483.35(a)

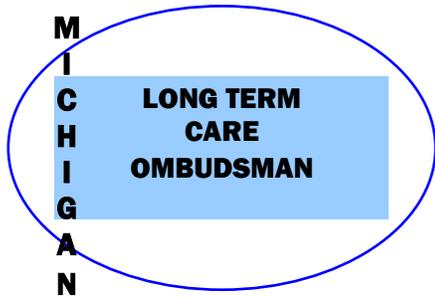
C. Federal Guidance to Surveyors

F Tag 361

D. State rule

- (a) Dietary or food services in a home shall be supervised by an individual who meets any of the following qualifications:
- (b) Is registered by the commission on dietetic registration of the American dietetic association.
- (c) Has completed all nutrition and related coursework necessary to take the registration examination required to become a registered dietitian.
- (d) Is a graduate of a dietetic technician training program approved by the American dietetic association.
- (e) Is a graduate of an approved correspondence or classroom dietetic assistant training program which qualified such person for certification by the hospital, institution, and educational food service society.
- (f) Is a graduate of a dietetic assistant training program granted approved status by the Michigan department of public health before July 6, 1979.
- (g) When the dietary or food services supervisor is other than a registered dietitian, the supervisor shall receive routine consultation and technical assistance from a registered dietitian (R.D.). Consultation time shall not be less than 4 hours every 60 days. Additional consultation time may be needed based on the total number of patients, incidence of nutrition-related health problems, and food service management needs of the facility.

Michigan Administrative Code R 325.20801



Fact Sheet

Smoking in Nursing Homes

Rights of smokers

As of May 1, 2010, Michigan law prohibits indoor smoking in public spaces and places of employment. Nursing homes are explicitly covered by the new statute. Therefore, nursing homes can no longer have designated “smoking rooms.”

The new law has no effect on smoking outdoors.

Federal regulations provide a resident has the right to "make choices about aspects of his or her life in the facility that are significant to the resident." 42 CFR 483.15(b)(3).

In the State Operations Manual, the Centers for Medicare and Medicaid Services provide Surveyor's Guidelines for Long Term Care facilities. Federal Tag Number 242 relates to 42 CFR 483.15(b).

The Guidelines, specifically addressing 42 CFR 483.15(b)(3), contain the following language:

[I]f a facility changes its policy and prohibits smoking, it must allow current residents who smoke to continue smoking in an area that maintains the quality of life for these residents. Weather permitting, this

may be an outside area. Residents admitted after the facility changes its policy must be informed of this policy at admission.

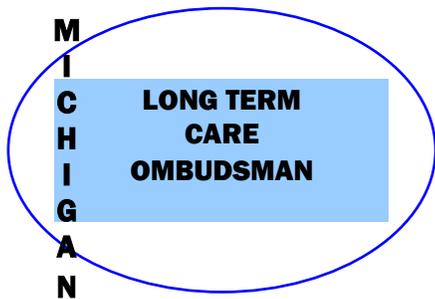
...

A nursing home cannot force a resident to wear a nicotine patch or receive any type of medical intervention aimed at stopping the resident from smoking, for a resident has the right to refuse treatment. 42 CFR 483.10(b)(4).

....

In summary,

- There is no smoking indoors at a nursing home.
- A nursing home has the right to establish a smoke-free campus.
- If a nursing home establishes a smoke-free campus, it must inform incoming residents they will not be permitted to smoke on the grounds.
- Even if a nursing home establishes a smoke-free campus, it must accommodate those individuals who are residents at the time the policy is put in place. A home must allow those individuals to smoke outdoors, and to provide assistance, if necessary.



Fact Sheet

Resident Councils in Nursing Homes

WHAT IS A NURSING HOME RESIDENT COUNCIL?

A resident council is an independent, organized group of persons living in a nursing home who meet on a regular basis to discuss concerns, develop suggestions and plan activities.

Sizes and structures of councils vary widely. Some resident councils function well with up to 50 residents at meetings. Others are effective with only a few active members. Leadership styles vary, as does the amount of resident participation.

WHY HAVE A RESIDENT COUNCIL?

The lives of nursing home residents are subject to many constraints, whether due to limitations of the resident, living in a group environment or policies and procedures of the nursing home. These constraints and controls can make nursing home residents feel like their opinions and preferences do not matter.

Many nursing home residents are not content to give up all control over their lives. They want an active role in life and the chance to influence decisions that affect them. A resident council gives them that chance.

WHAT CAN EFFECTIVE RESIDENT COUNCILS ACCOMPLISH?

- Improve communications within their homes. They are known as places to get the facts and can help dispel rumors.
- Help identify problems early, when it is easier to do something about them. They are an important part of the grievance process and help avoid the necessity of discussing problems with outside sources.
- Serve as a sounding board for new ideas.
- Help individuals speak out about what's bothering them and help overcome fear of retaliation. When people are dependent on others for their needs, there is fear that they may make others so angry that care will be withheld. Resident Councils lessen the fear, because speaking up as a group is easier than as an individual.
- Improve the atmosphere of the homes where they are active. The staff appreciates having residents share in some of the responsibilities of planning activities and events.
- Promote friendship. By working in small groups that meet regularly, residents have a chance to get to know each other well.

DO RESIDENTS HAVE A RIGHT TO MEET AS A COUNCIL?

Yes. Michigan and Federal laws give residents the right to meet as a council. At the time of admission, nursing homes are required to inform new residents of their right to establish a council if one does not exist or to participate in the activities of a council that is already operating. The home must also provide space for meetings and give assistance to residents who need help getting to the meetings.

Councils have the right to meet privately or to invite members of the home's staff, relatives, friends, or members of community organizations to participate in the meetings. The home must designate a staff person to serve as liaison to the council, to attend council meetings if requested, and to provide needed support services and assistance, such as typing of minutes and correspondence.

HOW ARE RESIDENT COUNCILS ORGANIZED?

The structure of a resident council can be the key to its success. The size of the home and the abilities and needs of the residents are important factors to consider in selecting a structure.

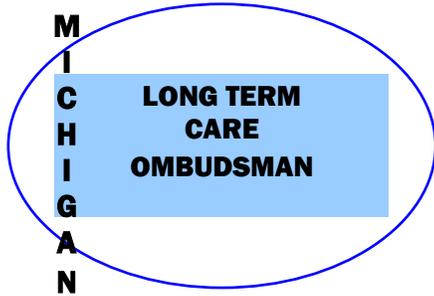
In small homes, resident councils are frequently operated as open meetings for all interested residents. There may be a steering committee to help plan meeting agendas and to follow-up on decisions made by the council.

Larger homes often have councils made up of representatives who are responsible for seeking the concerns and suggestions of residents in their area and for bringing this information to the meetings.

WHERE CAN ONE GET MORE INFORMATION ABOUT RESIDENT COUNCILS?

If you need more information about resident councils, please contact your ombudsman, toll-free:

1-866-485-9393



Fact Sheet

Family Councils in Nursing Homes

WHAT IS A FAMILY COUNCIL?

A family council is an organized group of relatives and friends of a nursing home's residents who meet on a regular basis to discuss issues and concerns regarding the home.

WHAT ARE THE PURPOSES OF A FAMILY COUNCIL?

The main purposes of most family councils are to protect and improve the quality of life in the home and to give families a voice in decisions that affect them and their loved ones in the facility. Specific purposes vary greatly from council to council. Examples include:

- Support for families
- Education and Information
- Discussion and action on concerns and complaints
- Services and activities for residents

- Joint activities for families and residents

WHAT ARE THE BENEFITS OF A FAMILY COUNCIL?

Effective family councils benefit families, residents, and the homes in which they are involved. Family councils allow families to give each other the support, encouragement, and information they need. No one knows as well as a family member how difficult it is to place a loved one in a nursing home. Even after placement, families continue to share similar concerns, problems and questions. Council involvement helps provide family members an opportunity to express their ideas and concerns and a way to work for positive change.

Residents of the home are also likely to benefit from the family council. Family involvement helps make a nursing home more homelike. Residents also benefit from council efforts to improve the quality of life in the home. Family council involvement can especially benefit residents who are physically or mentally unable to voice their concerns and needs for themselves.

The nursing home also receives benefits. Councils allow the nursing staff to deal directly with family concerns and ideas, to convey needed information to families, and to establish meaningful lines of communication. The nursing home administrative staff may be able to use the family council as a sounding board for new ideas.

HOW ARE FAMILY COUNCILS ORGANIZED AND STRUCTURED?

Some family councils are initially started by nursing home staff, often at the administrator's request. Nursing home volunteers or community leaders start by interested families or friends or other councils.

Although the organizational structures of family councils vary greatly, there are some common features of most councils. Family councils are run by friends

and relatives of the home's residents, choose their own topics, have elected leadership, meet on a regular basis, and have some method for exchanging information with the nursing home staff. Two structures are common:

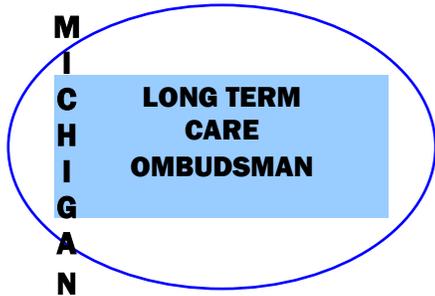
1. **Town Meeting Model** – If the group of interested families and friends is small, the council usually invites all families to each meeting. Planning, decision-making, and other basic tasks are carried out at these meetings.
2. **Executive or Planning Committee** – If the group is large, a committee may be needed to plan and make decisions that would be too time consuming to deal with in meetings of the full council. The committee may meet monthly and plan bimonthly or quarterly events or projects to which all families are invited.

IS A FAMILY COUNCIL MEETING A “FAMILY NIGHT?”

No. Family night is a name used in many nursing homes for occasional educational or social functions planned and hosted by the nursing home staff for families and friends of the home's residents. While these programs may be beneficial, they are different than a family council that is run by the relatives and friends themselves.

DO RELATIVES AND FRIENDS HAVE A RIGHT TO ORGANIZE A FAMILY COUNCIL?

Yes. All citizens have constitutional and statutory rights to organize and meet to discuss issues of concern. Medicare- and Medicaid-certified nursing homes must allow family councils to operate and must provide meeting space in the facility for their activities. Michigan law also gives family members of nursing home residents the right to present concerns without retaliation.



Fact Sheet

How to File a Nursing Home Complaint

What should I do if I have a complaint about a nursing home?

Usually, the first step is to talk with the nursing home administrator or director of nursing about the problem.

What if the administrator refuses to adequately address the issue?

An individual can file a complaint with the Bureau of Health Systems, the part of the Michigan Department of Community Health that regulates nursing homes.

Who can file a complaint with the Bureau of Health Systems?

A resident in a nursing home, a family member or anyone interested in the welfare of a resident has the right to file a complaint.

What can I complain about?

The subject of a complaint can be any aspect of a resident's life, such as the behavior and attentiveness of staff, the quality or choice of food, violation of residents' rights, inappropriate actions of another resident, or improper medical care.

Can a complaint contain more than one issue?

Yes.

How can I file a complaint?

There are several methods to file a complaint.

1. Call the toll-free Complaint Hotline, 1-800-882-6006.
2. Submit the complaint on-line. Go to www.michigan.gov/lara. On the left side of the screen, click on “licensing and regulation;” then on the left side of the screen, click on “health systems forms;” under the title, “Nursing Homes and Long Term Care” in the middle of the page, click on “BHS Health Facility Online Complaint Form” and follow the directions.
3. Mail a completed Nursing Home Complaint Form (BHS –OPS-361a) (a copy of which is attached to this fact sheet), or a letter, to

Michigan Department of Licensing and Regulatory Affairs
Bureau of Health Systems, Division of Operations
Complaint Investigation Unit
PO Box 30664
Lansing, MI 48909

What information will I need to provide?

Whichever method you use, you will need the name and address of the nursing home; the name of the resident, the nature of the complaint, the date of the incident, and your name, address and daytime telephone number.

The more detailed and precise the information you give about the issue or incident, the better.

Can I file a complaint but not give my name?

Yes, but it can make it more difficult for the investigator to collect information, as there will be no way to contact you

If you give your name, your name shall not be disclosed unless you give permission or disclosure is considered essential as part of the investigation. In the latter case, you will be given the opportunity to withdraw your complaint

What does the Bureau of Health Systems do upon receiving a complaint?

When the Bureau of Health Systems receives a complaint, staff will identify possible violations of state and federal law and regulations, assign a priority based on the severity of the allegations, and assign the complaint for investigation.

The Bureau will send a letter to the individual filing the complaint, confirming the complaint has been received.

How long will it take before an investigation is started?

There are time lines depending on the severity of the allegation, but these are not always met. If there are allegations of what is known as “immediate jeopardy,” the investigation must be started within two business days.

In the past, it has taken the Bureau of Health Systems months to begin an investigation of some complaints considered less serious.

Will the investigator contact me?

The investigator is supposed to contact you at the start or during the investigation.

How is the investigation conducted?

An investigation consists of three parts: a review of the medical record; observation; and interviews, which could include staff and residents.

The standard of proof of an allegation is “preponderance of the evidence.” In simpler terms, investigators seek evidence to determine whether it is more likely than not that the event occurred.

What happens when the investigation is completed?

Once the investigation is completed, you will receive a written report with the findings. For each issue, the investigation will find it “substantiated” or “unsubstantiated.”

What do these terms mean?

Essentially, the words mean “proven” and “unproven.” If the Bureau finds a complaint unsubstantiated, it does not mean the events complained of didn’t happen. Rather, the Bureau did not find enough evidence – at the time of the investigation - to conclude it did.

What happens if a complaint is substantiated?

If a complaint is substantiated, the Bureau will assign a numbered citation depending on what federal or state law regulatory provision has been violated.

The nursing home and you are informed of these citations in a “Statement of Deficiencies,” and informed of the corrective actions the nursing home must take. The Bureau can also initiate an enforcement request resulting in fines for the nursing home and other remedies.

What if I am dissatisfied because the Bureau finds a complaint unsubstantiated?

The letter you receive with the findings of the investigation will inform you how to appeal by asking for an administrative hearing within 30 days.

However, the appeals process is only a determination whether the investigation was thoroughly done. In the hearing, the administrative law judge does not have power to determine if the complaint is substantiated; she or he can only order another investigation be done.

Michigan Department Of Licensing and Regulation

Complaint Investigation Unit

NURSING HOME COMPLAINT FORM

Print clearly or type information on all sections of this form. Call 1-800-882-6006 if you need help completing the form.

RESIDENT INFORMATION

Resident's Name _____
Birth Date/Age _____
Date Admitted _____
Room # _____
Discharge Date (if no longer in facility) _____
Guardian/Resident Representative _____
Daytime Phone _____ Evening Phone _____

FACILITY INFORMATION

Facility Name _____
Facility Street Address _____
City _____ State MI Zip Code _____

INFORMATION ABOUT PERSON FILING THE COMPLAINT

Your Name (if not resident) _____
Daytime Phone _____ Evening Phone _____
Street Address _____
City _____ State _____ Zip Code _____
E-mail Address _____

All nursing homes are required to post the name, title, location, and telephone number of an individual in the nursing home who is responsible for receiving complaints and conducting complaint investigations. Someone in the nursing home should be on duty 24 hours a day, 7 days a week to respond to complaints. You may wish to contact the facility representative or administrator before filing this complaint.

Sign this form when completed and submit it to the Bureau of Health Systems by mail or fax to:

Michigan Department of Licensing and Regulatory Affairs
Complaint Investigation Unit

P.O. Box 30664, Lansing, MI 48909

Fax # (517) 241-0093

Other agencies that help citizens with complaints are:

The State Long Term Care Ombudsman Program will help identify, investigate and help resolve complaints of residents of licensed long-term care facilities through its network of local ombudsmen. Call 1-866-485-9393 (toll-free)

The Department of Attorney General (AG) investigates elder abuse and Medicaid fraud. Call: 1-800-242-2873 or file a complaint online at <http://www.michigan.gov/ag/>

Michigan Protection & Advocacy Service (MPAS) can tell you who you should call to report abuse/neglect, help you file a complaint, or investigate an abuse/neglect allegation. Call: 1-800-288-5923 or (517)487-1755 <http://www.mpas.org/>

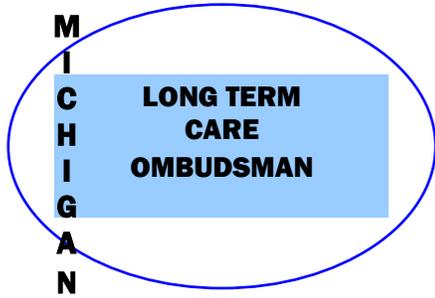
BHS-OPS-361a (Rev. 12/03) Authority: MCL 333.21799a Completion: Voluntary
The Michigan Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this Agency

Scope and Severity Matrix for Citations

Scope of the Deficiency

(number of residents affected)

		<u>Isolated</u>	<u>Pattern</u>	<u>Widespread</u>
		A	B	C
Severity of the Deficiency	No actual harm with potential for minimal harm	A	B	C
	No actual harm with potential for more than minimal harm that is not immediate jeopardy	D	E	F
	Actual harm that is not immediate jeopardy	G	H	I
	Immediate jeopardy to resident health or safety	J	K	L



Fact Sheet

Estate Recovery

What is estate recovery?

Estate recovery is a program through which the state is repaid for Medicaid benefits provided to certain individuals, with repayment occurring no sooner than a recipient's death.

Why is the focus of estate recovery on the home?

Although estate recovery applies to assets other than the home, a Medicaid recipient's home may be her or his only valuable asset.

When did estate recovery begin in the United States?

Legislation establishing Medicaid in 1965 **permitted** states to recoup Medicaid benefits paid to people age 65 or older. About 7 states established estate recovery programs using this permissive language. Michigan was not one of these states.

When did it become mandatory for states to have an estate recovery program?

This requirement was set forth in the federal Omnibus Budget Reconciliation Act of 1993. 42 USC 1396p.

When did Michigan pass legislation to establish an estate recovery program?

The effective date of Michigan's law was September 30, 2007. MCL 400.112g et seq.

Why did it take Michigan so long?

The concept of estate recovery was not popular among state legislators. There are a number of policy arguments against it. Among these are –

- Estate recovery is unfair because some individuals will avoid it through estate planning or other means
- The policy only affects individuals of a certain age, receiving benefits from a particular program
- Individuals will give up control over their homes – for example deeding the home to children – long before the need for Medicaid arises
- Family will not properly maintain a home or pay the taxes if they know the home will be sold and proceeds go to the state
- Individuals may defer seeking needed services covered by Medicaid
- The program is not likely to generate substantial revenue, and a state can use the revenue for any purpose it chooses

When did estate recovery begin in Michigan?

The process of recovery began July 1, 2011. MSA Bulletin 11-20

provides that recovery applies to services received on or after July 1, 2010. (This policy conflicts, in part, with state law, which exempts any individual who began receiving Medicaid before September 30, 2007.)

What happened between the effective date of the statute in 2007 and implementation of the program in 2011?

State legislation required that approval of the federal government before the program could begin. There were negotiations between the state and federal officials during these years.

In mandating estate recovery, what options did the federal government give the states?

A state could choose to -

- cover Medicaid services received after age 55; or individuals after age 55 **and** individuals of any age who were “permanently institutionalized”
- obtain recovery from only the “probate estate” or from all assets of the decedent
- utilize pre-death liens or not

Which choices did Michigan make its 2007 legislation?

Michigan chose to include only individuals after age 55; recovery only from the probate estate; and not to utilize pre-death liens.

What is the “probate estate?”

When an individual dies, certain assets pass directly to another person without going through probate. These assets include jointly-held property; life insurance proceeds with a named beneficiary; pension benefits with a named beneficiary and property held in trust.

The probate estate includes all assets that do go through the probate process.

Is the entire probate estate subject to estate recovery?

No, only that part of the estate that is left after payment of the expenses of funeral and burial, a mortgage, court fees, and certain allowances set forth in law. These can total as much as \$58,000 if the individual leaves a spouse or dependent child, or about \$14,000 if there is no spouse but there are adult children.

Under federal and state law, who must be exempt from IMMEDIATE estate recovery under federal law?

Recovery cannot be made from the home if the spouse or a child under age 21 or disabled; or other relatives (in certain circumstances) are living in the home.

Recovery can occur when the spouse dies unless there is a child under age 21 or disabled. (There are certain other circumstances when recovery from the home is delayed even longer.)

How will the state try to ensure payment upon the spouse’s death?

The state can put a lien on the home after the death of the recipient; the

lien will be paid when the house is sold or the spouse dies.

Are there instances when estate recovery will never occur?

Yes. Federal law requires a “hardship waiver” be available, but leaves the definition of hardship to the states.

Michigan law provides a waiver is available if the estate is the primary income-producing asset of the survivors, such as a family farm or business. (But the new Medicaid State Plan says the asset must be the SOLE income-producing asset of the survivors and the income from the asset is “limited.”)

Michigan law also exempts as a hardship 50% of the average price of a home in the county where the home is located. (But the Medicaid State Plan has much narrower language: The value of the home must be no higher than 50% of the county average.)

Are there circumstances other than hardship when recovery will not be pursued?

Yes. First, if the costs of pursuing the claim exceed the recovery amount. Second, if recovery would make an heir eligible for, or continue to be eligible for, Medicaid.

Who is administering Michigan’s estate recovery program?

The state has contracted with a private company, Health Managements Systems, Inc (HMS) to administer the program. By contract, HMS earns 13.9 percent of the money it collects.

Does the State of Michigan keep the rest of the money?

No. At least 50% of the balance must be returned to the federal government.

What happens to the money the state keeps?

There are no restrictions on how the state legislature decides to spend the money.

Does the state have an obligation to inform applicants for Medicaid about the estate recovery program?

Yes. And information on hardship waivers must be included.

What is the process of estate recovery once an individual dies?

- Upon finding out about a death, HMS sends out a *Notice of Intent to File a Claim Against Estate*, with *Michigan Estate Recovery Questionnaire* enclosed to the spouse or contact listed on the Medicaid application.
- The spouse or other person completes the questionnaire and returns it to HMS within 2 weeks
- The spouse or other person telephones HMS at 1-877-791-0435 and requests an *Application for Hardship Waiver*
- The *Application for Hardship Waiver* is completed by the spouse or other person who returns it to HMS within 60 days from date sent by HMS
- HMS issues a decision on exemption or hardship waiver

- Individual has right to appeal a denial

How does HMS find out about an individual's death?

In many instances, the Department of Human Services will provide HMS with this information.

A personal representative appointed through the probate process will have an obligation to contact HMS, if the personal representative is aware the individual received Medicaid benefits and may be subject to estate recovery.

Fact Sheet

How to Choose a Residence That is Right for You

When looking for a long term residence, including an adult foster care home, home for the aged or unlicensed assisted living, it is good idea to visit as many places as possible. This will give you an idea what options are available. While you are looking, you should consider your current needs and how those needs may change in the future. You should set some priorities for what is most important to you in a home, and determine what you can afford.

When you have narrowed down your choices, make another visit. Vary the time of the visit, come unannounced. To get a better idea of what life at the home is like, talk with residents and get their impressions.

If the facility is licensed as an Adult Foster Care Home or a Home for the Aged, ask to see the home's latest state inspection report. Review the report with the admissions person or administrator. Ask for clarification of any citation that impacts those things important to you.

CHECK LIST

Location

- Is the home in a convenient location?
- Is it close to community services and resources that you use (e.g., doctor

offices, shopping mall, movie theater, church)?

Environment and Safety

- Is the entrance to the home safe?
- Are the entry and parking lot well lit?
- How is the exterior appearance of the home?
- How is the interior appearance of the home; is it clean or cluttered?
- Is the home a comfortable temperature with good air circulation? Is there an odor?
- Are their working smoke detectors, emergency fire sprinkler system, and monthly fire drills?
- Does the home have a security system/alarms?
- Does staff know what to do in the case of an emergency or fire? (Ask staff)
- Is there an emergency call system?
- How are medical emergencies handled?
- Does staff appear pleasant, attentive to residents, and respectful?

- Is the staff well groomed?
- Which staff people provide direct care? (Talk to some care staff)

Staffing and Training

- What is the ratio of direct care staff to residents?
- Does the home bring in help from home health care agencies?
- What initial and ongoing training is provided for staff?
- How frequently are staff evaluations conducted?
- Who supervises direct care staff?
- If an RN is on staff, what are his/her hours, role, and responsibilities?
- Who provides additional services when needed?
- Are staff trained in preventive oral hygiene care?
- How long does the average person work for the home?
- What is being done to retain staff?

Quality of Life

- Do residents appear happy, relaxed, and comfortable?
- Do residents appear properly groomed and dressed?
- Do residents appear healthy?
- Is there a plan in place to maintain the quality of services and care for residents?
- Is there community involvement with the home? How is the home involved in the community? (e.g., daycare for children, block parties, meetings held at the home)
- How does the home accommodate family and friends who visit?
- Are residents involved in program design, evaluation, management, and policy development?
- Is the assistance of a physical or occupational therapist available?
- Does the residence have a dentist or dental hygienist on call?

Activities and Daily Living

- How are medications distributed, who supervises?
- Does the pharmacy provided delivery services, consultations, and medication review?

- Is there an activity schedule?
- Is there a variety of activities and times when they are offered? Is there an exercise program?
- Are there specific hours when guests may visit?
- Is there a private room available for entertaining guests?
- Are coffee, tea, and other beverages available to offer guests?
- What is the food like? (Ask if you can have lunch at the home)
- How are meals planned?
- Are special diets accommodated?
- Are residents involved in menu planning?
- Are snacks available during the day?
- Are bed linens and towels provided?
- Is transportation provided? Is there access to public transportation?
- How are personal likes and dislikes, habits, routines, and activities accommodated?
- Are religious services held at the home?

Services and Fees

- Ask for a copy of all forms requiring signatures so you can review them.
- Is there a Security deposit? Is there an application fee? Is the fee refundable?
- What is included in the basic fee?
- How often are rates increased? Ask for a 5-year history.
- Review services provided and fees for each individual service.
- How much notice is given to the resident regarding eviction or termination of services?
- Under what circumstances can the resident terminate the lease or contract?
- What will happen if medical needs increase so that the level of care is beyond what the home provides?
- What will happen when the resident's funds run out?

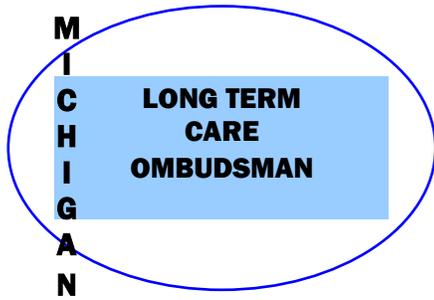
Moving In

- What is the process for moving in?
- Is there a needs assessment or initial evaluation done to assure the resident receives appropriate care and services?

- What happens to the resident's room during a temporary hospital admission?
- Ask for Resident Rights information.

Moving Out

- What is the home's policy and procedure for evictions?
- Does the home assist with locating an appropriate care setting?



Fact Sheet

Costs at an AFC, HFA or Unlicensed Assisted Living

The cost of residing at an adult foster care home, a home for the aged or in unlicensed assisted living varies from facility to facility. Costs will also vary within a facility depending on the services received.

Some people can afford to pay fees from their own income and savings. Others may have purchased Long-Term Care Insurance that pays all or part of the cost of assisted living. Unlike nursing homes, government financial assistance for assisted living is very limited. Many find it difficult to find affordable assisted living. And if private funds run out, it may be necessary to move to another facility

If you are considering moving into an ACH, HFA or unlicensed assisted living, one of the questions you should be asking yourself is, "how long can I afford to live in this facility?" You should consider not only current costs and fees, but future increases. You also need to think about how your care needs may change and how that will impact costs. Some of the questions you should ask when you visit a facility are -

- What is included in the basic fee? What is charged as an extra fee?
- When and how often are rates increased? Ask for a 5-year history.
- What is the facility's refund policy?

- Under what circumstances will services be terminated by the facility?
- What happens if medical needs increase or the level of care changes?
- What happens if funds run out?

You should read an admission agreement very carefully before signing. Make sure provisions in the document are the same as you have told, If not, ask for clarification or, ask to have the agreement changed to reflect what you have been told.

Government Assistance - MDCH

Some government assistance is available for residents of Adult Foster Care homes and Homes for the Aged who meet strict eligibility standards.

The Michigan Department of Community Health through Community Mental Health Services helps pay for Adult Foster Care homes or Homes for the Aged for individuals who have a developmentally disability or who have a mental illness

Veterans Administration

The Veterans Administration provides pension benefits to veterans, their spouses, and widows or widowers with limited incomes. Pension benefits are higher for persons needing daily assistance with personal needs. Residents of Adult Foster Care homes or Homes for the Aged may qualify for these benefits. Information can be obtained by calling the Veterans Administration at 1-800-827-1000.

Medicare and Medicaid

Medicare does not pay for room and board. However, it will continue to pay for covered medical expenses, such as hospital care, prescribed home health services, and doctor visits. Medicaid may be available to some residents. It will not pay the fees for room and board, but it may pay medical expenses including prescription medicines. If you have questions about Medicare and Medicaid benefits, the Medicare Medicaid Assistance Program at 1-800-803-7174 can explain what programs are available and how to qualify.

Supplemental Security Income

The Social Security Administration runs an income supplement program for low-income blind, aged, and disabled people. This program is called Supplemental Security Income (SSI). If you qualify for SSI, you are paid a monthly check to bring your total income up to the SSI limit.

To qualify for SSI, you must have less than \$2,000 in countable resources (a couple may have up to \$3,000 in countable resources). Resources are things you own, such as, savings and checking accounts, cash, and stocks and bonds. Property that is not counted includes your home, a car, personal and household goods, some life insurance, and certain funeral contracts and accounts.

Your income must also be limited. Income means monthly earnings such as, Social Security or Railroad Retirement Benefits, pensions, and other money you may receive. To be eligible for SSI in an adult foster care home or home for the aged in 2009, your income must be below -

- \$831.50 per month for personal care in an Adult Foster Care home
- \$853.30 per month for personal care in an Home for the Aged

You apply for SSI at your local Social Security office. Additional information can be obtained from the Social Security Administration at 1-800-772-1213. If you qualify for SSI, you automatically qualify for Medicaid.

Some Adult Foster Care Homes and Homes for the Aged accept SSI payment levels as payment in full. If the AFC or HFA accepts SSI, it cannot charge you more than this amount for its services.

However, an Adult Foster Care Home or Home for the Aged is not required to accept a resident receiving SSI. If you convert from private pay to SSI, you may have to transfer to another home. You should find out before moving in whether the home you are considering accepts SSI payment.

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**LONG TERM
CARE
OMBUDSMAN**

Fact Sheet

Your Rights as a Resident in a Home for the Aged

Homes for the Aged provides room, board, and supervised personal care to individuals who are 60 years or older. The Office of Children and Adult Licensing is responsible for overseeing Homes for the Aged.

As a resident of a Home for the Aged in Michigan, you have the right to:

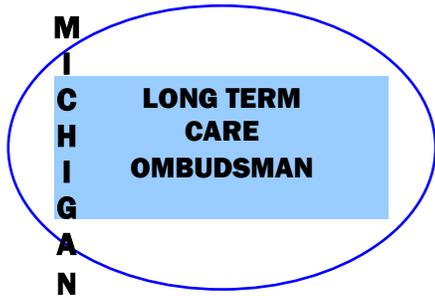
- receive appropriate care, regardless of race, religion, color, national origin, sex, age, disability, marital status, sexual preference, or source of payment
- have your personal and medical records kept confidential and receive a copy of records
- have privacy
- raise your concerns without fear or discrimination or reprisal
- receive and examine an explanation of your bill
- know who is responsible for and who is providing your direct care

- communicate and consult with an attorney, physician, or any other person of your choice
- send personal mail, and receive unopened mail the same day it is received
- meet with, and participate in, the activities of social, religious, and community groups, or to refuse to participate
- be free of mental or physical abuse, and from physical or chemical restraints
- communicate privately with persons of your choice
- keep your own clothes and possessions as space permits
- be informed of services available in the home and the related charges
- manage your own financial affairs

It is the responsibility of a home to make sure that each resident's needs are being continuously identified and met. At the time of admission the home must complete a **Resident Evaluation** form. This should be reexamined anytime there is a concern about a resident's care.

A HFA is required to have a written **grievance procedure** and must give you information about how to make a formal complaint to the administrator. If your concerns about your care or your rights cannot be resolved at the home, a complaint can be filed with the **Office of Children and Adult Licensing, Complaint Intake Unit**. Call toll-free: **1-866-586-0126**

For more information please call our toll free number: **1-866-485-9393**



Fact Sheet

Homes for the Aged Complaints

The **Office of Children and Adult Licensing** in the Department of Human Services licenses and regulates Homes for the Aged (HFA). Homes for the Aged are inspected annually to determine whether they meet state standards. The Office is also required to investigate all written and oral complaints about resident care and treatment, staffing, sanitation, and other conditions and services in HFAs.

Most problems in an HFA can be resolved without filing a formal complaint. Often a phone call or a conversation with the right person at the home can resolve a problem. Less frequently, it is necessary to file a complaint with the Office of Children and Adult Licensing. The federal government has established the **Long Term Care Ombudsman Program** to help residents who have complaints about care or services. An ombudsman can help you regardless of how serious your concerns are, and if you wish, assist you with filing a formal complaint.

If you decide to file a formal complaint against a Home for the Aged, please consider the following information:

1. Anyone can file a complaint with the Office of Children and Adult Licensing against an HFA. Although you can call the Office with your concerns, it is best to make your complaint in writing.

2. You can file a complaint anytime within a year of the event or circumstances you are concerned about.
3. In your letter state that you are making a formal complaint and give the name and address of the HFA.
4. Be as specific as possible about the incidents, injuries, or acts you want investigated. It is best to organize your letter around specific issues rather than telling a story of each day's events.
5. Always include dates, times, names, places, and the people involved. If any resident(s) were affected, be sure to include his or her name in your complaint.
6. Be sure to include your full name, address, and daytime telephone number where you can be reached.
7. If there are any witnesses or other parties who wish to provide information about your complaint, include their names, addresses and daytime telephone numbers so they can be contacted during the investigation.
8. It is always helpful to include copies of bills, invoices, letters, death certificates, or other relevant documents.
9. Keep a copy of your letter for your own records and send a copy of it to your local long-term care ombudsman.
10. If you feel that you must remain anonymous or that you cannot reveal the name of the resident, you can still contact the Office of Children and Adult Licensing, or send a letter without any names. However, it will be

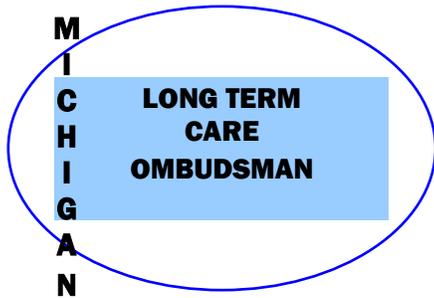
more difficult for the Licensing Consultant to investigate your concerns or a specific event.

Written complaints should be sent to:

**Department of Human Services
Office of Children and Adult Licensing
Complaint Intake Unit
7109 W. Saginaw, 2nd Floor
P.O. Box 30650
Lansing, MI 48909**

If you have access to the Internet, a complaint can be submitted online by going to the DHS website at www.michigan.gov/dhs and clicking on Doing Business with the DHS in the left hand column, Licensing, and then Complaints in the Contact Us box. You may also file a complaint by calling toll free: **1-866-856-0126**

For more information please call our toll free number: **1-866-485-9393**



Fact Sheet

Your Rights as a Resident in an Adult Foster Care Home

Adult Foster Care homes are facilities that provides supervision, personal care, and protection in addition to room and board, for 24 hours a day, 5 or more days a week, and for 2 or more consecutive weeks for compensation.

There are three types of AFC homes in Michigan: **Family Homes** (6 or fewer residents, the owner lives on-site), **Small Group Homes** (12 or fewer residents), and **Large Group Homes** (13-20 residents).

The homes are licensed and inspected by licensing consultants from the Office of Children and Adult Licensing. Though rules and regulations may vary between these three types of homes, your rights remain the same. You have a right to -

- be free from discrimination because of race, religion, national origin, sex, age, handicap, marital status, or source of payment
- exercise constitutional rights, including the right to vote, to practice the religion of your choice, etc.
- send and to receive unopened and uncensored mail

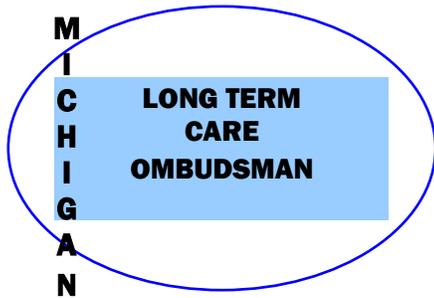
- participate in social, religious and community activities, as well as the right to not participate
- contacts with relatives and friends, and to receive visitors in the home at a reasonable time.
- private communications and consultations with a physician, attorney, or any person of your choice
- choose a physician, psychiatrist, or dentist for needed services
- refuse treatment and services, and to be told of the possible consequences of that refusal
- private use of a telephone every day
- access to your own room at your discretion
- voice complaints and make recommendations for change without fear of retaliation
- be treated with consideration and respect, with recognition of personal dignity, individuality and the need for privacy
- nutritious, appetizing meals
- be free from harm and punishment by restraint, isolation, personal humiliation, or by having food, water, or personal items withheld
- review and discuss your records with the home's staff, including the assessment and care plans

- use the services of advocacy agencies and to attend other community services
- request and receive assistance from a responsible agency to relocate to another living situation

At the time of admission a **Resident Care Agreement** between the resident and the home must be completed. This agreement must be reviewed annually, but can be reviewed anytime there is a concern about the level or quality of care being provided. The home should have a process for addressing concerns to the staff or administration. You should consider putting any complaints in writing to document steps taken to resolve conflicts.

If you cannot resolve issues with the home, a complaint can be filed with the **Office of Children and Adult Licensing**. Toll free: **1-866-856-0126**. After investigating a complaint, the Office can require that the home prepare a plan of correction; fine the home; or suspend, modify, or revoke a home's license.

For more information please call our toll free number: **1-866-485-9393**



Fact Sheet

Adult Foster Care Home Complaints

The **Office of Children and Adult Licensing** in the Bureau of Human Services licenses and regulates Adult Foster Care (AFC) homes and is required to investigate complaints made against AFC homes. You may file a complaint by calling the Complaint Intake Unit at **1-866-856-0126** (toll free), faxing 517-241-1680. or by sending a written complaint to:

**Department of Human Services
Office of Children and Adult Licensing
Complaint Intake Unit
7109 W. Saginaw, 2nd Floor
P.O. Box 30650
Lansing, MI 48909**

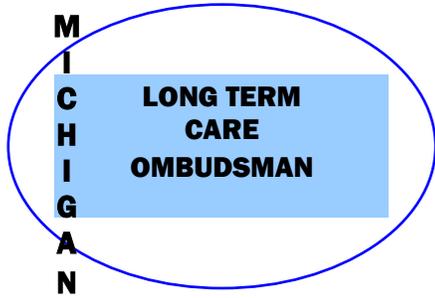
If you have access to the Internet, a complaint can be submitted online by going to the DHS website at www.michigan.gov/dhs and clicking on Doing Business with the DHS in the left hand column, Licensing, and then Complaints in the Contact Us box.

The Office of Children and Adult Licensing must initiate an investigation within 15 days of receiving a written complaint. If the Office receives an oral complaint, it must help the complainant put the complaint into writing within 7 days of a request for assistance. Whether the complaint is received in writing or orally, the Office must provide you with the investigation results within 30 days

of receiving the complaint, or provide you with a status report indicating when the results of the investigation can be expected.

Your name will not be disclosed to the AFC or as part of the public record unless you give your consent. If disclosure of your name is essential to the investigation, you will be given the opportunity to withdraw your complaint. If you are filing a complaint on behalf of a resident, their name will also remain confidential. If you wish to file a complaint against an adult foster care home, the following may help you in writing a letter to the Office of Children and Adult Licensing:

1. In your letter, state that you are making a formal complaint and include the name and address of the AFC home. Only formal complainants have the right to receive a copy of the investigation report and to request a hearing if they are dissatisfied with the investigation.
2. Give your name, the name of the resident if you are filing a complaint on their behalf, address, and telephone number(s) where the Licensing Consultant can contact you during the investigation.
3. Be very specific about what happened, when it happened, how it happened, who was involved, and any other details. Use names, dates, and times. It is best to organize the letter around specific issues rather than telling a story of each day's events.
4. Always keep a copy for yourself and send a copy of your letter to your Local Long Term Care Ombudsman.
5. If you feel that you must remain anonymous or that you cannot reveal the name of the resident, you can still contact the Office of Children and Adult Licensing, or send a letter without any names. However, it will be more difficult for the Licensing Consultant to investigate your concerns or a specific event.



Fact Sheet

What is Assisted Living?

"Assisted Living" is a popular term for long-term care in a setting other than a traditional nursing home. "Assisted living" is actually a marketing term, and has no legal definition or legal standing in state or federal regulations.

There are only three types of long-term care licenses in the state of Michigan, nursing home, adult foster care (AFC), and home for the aged (HFA).

Types of living arrangements with catchy names, such as "independent living", "senior service apartments" are probably unlicensed.

Some facilities are now offering "continuum of care" campuses, where residents can move from independent apartments to assisted living to skilled nursing, all in the same location.

Services

Providers offer a range of services. **There are no requirements for minimum services**, but the facility might provide some or all of the following:

supervision and security

medications management

group activities

meals

some assistance in bathing

some assistance in toileting

some assistance in grooming

on-call nurses

some assistance in dressing

transportation

housekeeping & laundry

initial evaluation

If the facility is unlicensed, there is no requirement that caregivers be licensed or certified in any way.

Finding a Qualified Provider

As a consumer you need to be very careful about selecting a residence. Some assisted living facilities do a great job, and others generate many complaints. Your local ombudsman may be aware of a complaint history. It may be helpful for you to call and see if any complaints have been filed recently.

How affordable is Assisted Living?

The average cost of assisted living is \$2500 to \$3500 per month, depending on how many services are needed. Some facilities charge a basic fee for room and board. Each additional service generates an additional fee. Other facilities provide services in “packages”.

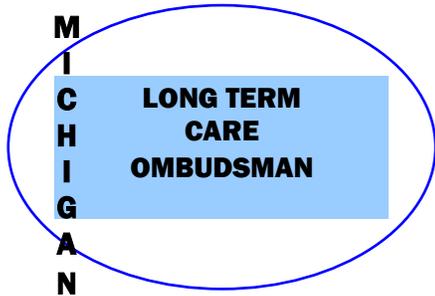
Few assisted living facilities accept any government benefit monies, such as Supplemental Security Income (SSI) or Medicaid. If a resident can no longer pay privately, he or she will likely need to move.

Is Anything Missing from Current Assisted Living Services?

One very important service seldom offered in unlicensed assisted living facilities is *services coordination*. Services are not usually coordinated in a comprehensive care plan, which establishes goals for maintenance or improvement of the resident's function. The initial evaluations do not include an in-depth assessment of the person's life and medical history. Without this *comprehensive assessment* and a care plan based on its findings, persons in assisted living could be at risk of preventable decline and premature need of nursing home care.

What If Problems Occur In Assisted Living?

There is very limited state oversight of unlicensed assisted living facilities. The state will investigate if they believe an unlicensed home is providing services and care that would require licensure. Otherwise, a resident's recourse is limited to the admission contract signed with the provider. If that provider is unresponsive to complaints, consumers may find their only option is to take their business elsewhere, pursue legal action against the provider, or both.



Fact Sheet

Your Rights in Unlicensed Assisted Living

The contract and/or lease signed by the resident of an unlicensed facility will determine the rights and responsibilities of both the resident and the facility. In addition to the contract, provisions of Michigan's and "landlord - tenant" laws will provide you certain rights.

An unlicensed assisted living facility is obligated to provide those services it has contractually agreed to provide, usually room and board and supportive services. A resident in need of more care than the facility is able to provide, may have the option of employing a home health agency to assist them with care needs.

If you are unhappy with the services you are (or are not) receiving, you should check your contract or admission agreement for a grievance procedure.

Residents who can no longer remain independent with services available may be asked to move out of the facility. An eviction will be governed by the terms of the contract and/or lease signed by the resident. In addition, the resident will receive the protections guaranteed by Michigan's landlord - tenant laws.

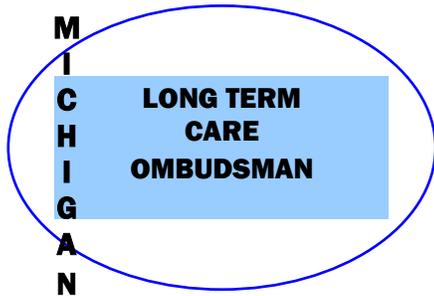
If you are concerned about the quality of care an unlicensed facility is providing, you can file a complaint with The Michigan Department of Human Services, Office of Children and Adult Licensing.

However, the Office of Children and Adult Licensing has no authority to require an unlicensed facility to meet its contractual responsibilities or to sanction them for providing substandard care. A licensing consultant will investigate if there is a concern that the facility is providing care services that would require it to be licensed, i.e. ongoing supervision, protection, and personal care. They can order a facility to stop providing care services or apply for the appropriate license.

If the health and safety of a resident is in jeopardy, a call can be placed to Adult Protective Services. This may result in the resident being transferred to a more appropriate care setting.

For more information please call our toll free number:

1-866-485-9393



Fact Sheet

Advance Directives

Adults have the right to make their own decisions, including where to live, how to spend their money, and what type of medical treatment to receive. These include difficult decisions about long term care and end-of-life care.

There may come a time when you are unable to manage your health care. Your ability to make or communicate decisions could be affected by a serious illness, an accident, a chronic disease, or a form of dementia like Alzheimer's disease.

While you are of sound mind, you have the right to sign one or more documents that provide direction for your care should you become unable to participate in medical treatment decisions. Collectively, these types of documents are known as *advance directives*.

Having any type of advance directive is voluntary; no one can force you to have one as a condition of admission or care. However, if you choose not to have an advance directive and you lose the ability to participate in decisions, there is a chance a court might appoint someone as your guardian to make decisions for you.

Durable Power of Attorney for Health Care

A durable power of attorney for health care (also known as a patient advocate designation) is an agreement by which you choose another individual to make care, custody and medical treatment decisions for you in the event you become unable to participate in medical decisions.

The individual you choose is known as your *patient advocate*. You may be as specific as you want in describing the medical treatments you wish to receive or not receive, or you may grant your PA complete discretion in making those decisions. If you have specific views on your end of life care, you should express them in the document.

In addition to giving your patient advocate authority to make medical treatment and care decisions, you may also give her or him instructions for organ donation.

There is no standard form for a durable power of attorney for health care. A number of fill-in-the-blanks forms are available at no cost. Any durable power of attorney for health care must be signed and witnessed to be legally binding.

Your patient advocate has no powers when you sign the document. Before a patient advocate can act, two events must occur. The patient advocate must have signed an “acceptance” (the language of which is set forth in statute). And two doctors, or one doctor and one psychologist, must examine you and determine you are unable to participate in treatment decisions.

You can revoke the agreement at any time, regardless of your mental state. You can sign a new document if you are still of sound mind.

Advance Directive for Mental Health Care

This document is similar in many respects to a durable power of attorney for health care, except that it applies only to mental health care, such as hospitalization on a psychiatric floor of a hospital.

You can specify in the document which hospital you prefer, whom you want as your mental health professional, what medications have worked (or not worked) for you in the past.

You can have both a durable power of attorney for health care and an advance directive for mental health care, and you can choose a different patient advocate for each.

Living Will

A living will is a document in which you describe what type of treatment you want or don't want if you are terminally ill or permanently unconscious, and no longer able to participate in medical treatment decisions.

Michigan is one of only three states that do not have a living will law. That does not prevent you from having a living will; it only means a health care provider is not required to honor it.

The document can be particularly useful for an individual who does not have someone to appoint as patient advocate.

Do-Not-Resuscitate Order

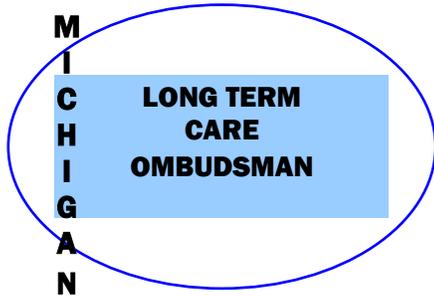
You may voluntarily sign a form if you do not wish to be resuscitated should your heart and breathing stop. The declaration is legally binding outside a hospital setting.

There are standard forms set forth in law for a do-not-resuscitate declaration.

. . . .

Once you sign an advance directive, you should share copies with your patient advocate, other family members and your doctor. If you are a resident in a nursing home, make sure the nursing home has a copy. If you go to the hospital, try to see that the hospital has a copy.

For more information about advance directives, including forms you can print, you can visit the website, www.michigan.gov/miseniors. (Click on "nursing home issues;" then click on "advance directives.") Or you can contact the ombudsman program, toll free, **1-866-485-9393**.



Fact Sheet

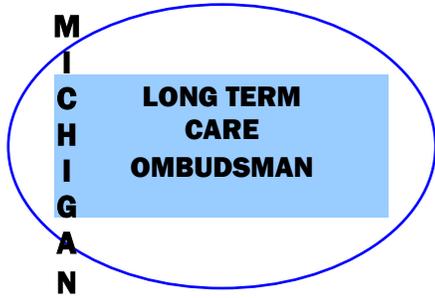
Federal Patient Self-Determination Act

As part of the Omnibus Budget Reconciliation Act in 1990, Congress passed the Patient Self-Determination Act. Under provisions of the Act, many health care providers receiving either Medicare or Medicaid funds have certain obligations.

- 1) Nursing homes, hospitals, hospice organizations and home health agencies must provide written information to each patient or resident regarding the individual's rights under state law to make decisions concerning her or his medical care, including the right to accept or refuse treatment.
- 2) The written material must include information on the right of the individual to sign a durable power of attorney for health care.
- 3) The material must include policies of the provider to implement rights of individuals to make decisions concerning their own health care.
- 4) These health care providers must document in the individual's medical record whether the individual has signed a durable power of attorney for health care.

5) A provider can not condition care on whether or not an individual has signed a durable power of attorney for health care.

6) Providers must establish education programs for staff and the community on these issues.



Fact Sheet

Do-Not-Resuscitate Orders

A "**do-not-resuscitate order**" is a document signed voluntarily by an individual stating that if her or his heart and breathing stop, she or he wants no resuscitation measures taken. Such measures would include mouth-to-mouth resuscitation, cardio-pulmonary resuscitation and defibrillation.

There are two standard forms in statute. One form is co-signed by a physician. The second form is for Christian Scientists and others who do not believe in "traditional" medical care. On that form, there is no line for a physician's signature.

The form can be signed by the individual her or himself or by the individual's patient advocate under a durable power of attorney for health care (assuming the patient advocate has been given authority to withhold life-sustaining treatment, in the document). An order can also be signed by a guardian who has been granted that authority by the probate court.

A do-no-resuscitate declaration is effective while the individual lives in a house, apartment, AFC, HFA, unlicensed assisted living or nursing home. An order signed under the Do-Not-Resuscitate Procedure Act is not applicable in a hospital.

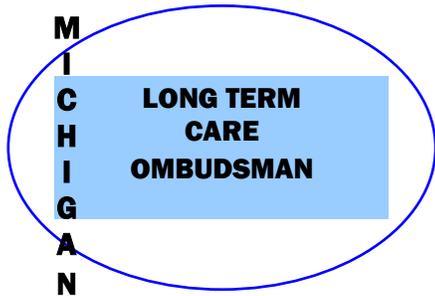
Whether the order is signed by the individual, the patient advocate or the guardian, the individual ALWAYS retains the right to revoke it. The revocation can be by any means the individual is able to communicate that intent.

It is a good idea for an individual to keep the signed order in plain view, e.g., on a refrigerator door, or for staff at a congregate facility to have access, just in case EMS workers arrive at the scene.

It is confusing, but a "**do-not-resuscitate-order**," (also known as a "**DNR order**") can also refer to a notation in a patient's hospital chart that no efforts be made to resuscitate if there is no sign of breathing and heartbeat.

A hospital do-not-resuscitate order can be entered by a physician at the request of the patient. The order can be entered at the request of the patient advocate (assuming, again, the patient advocate has been given the authority).

If a situation arises when a guardian has authorized a DNR hospital order, but the patient objects, the individual should request the probate court modify the guardianship to restrict the guardian's powers, replace the guardian, or terminate the guardianship.



Fact Sheet

Roles in Making Decisions For Another Adult

Under state and federal law, there are a number of roles a person or corporation can play in making or carrying out decisions for another individual. Sometimes there is a general term encompassing more than one role.

Each role is different, has its own name, and often has a unique source in the law. The terminology can be quite confusing.

A role can come about in one of three ways. One, an individual can appoint another person. Second, in appropriate circumstances, a court can appoint another person. Third, a role can be created through a family relationship.

This fact sheet sets out the roles, what each role entails, and a citation to the law. Please note a person can be serving in more than role for the same individual at the same time.

Agent

In general terms, an agent is a person or corporation whom an individual chooses to act in her or his behalf. Once the chosen entity accepts the role, the entity has a legal duty to the individual. One type of agent is an “attorney-in-fact.”

Attorney-in-fact

An agent appointed by an individual under a power of attorney or durable power of attorney for finances is also known as an attorney-in-fact. (This role should not be confused with the role of attorney-at-law, which is a fancy name for a lawyer.)

Under a power of attorney an individual could, for example, give a person authority to sign her or his name to closing documents in a home sale if the individual were out of town.

Using a *durable* power of finances, an individual can name another person to make or carry out financial decisions for her or him, including paying bills. The individual can choose to give the attorney-in-fact this power immediately, or to have the power only upon the individual becoming unable to manage her or his finances. MCL 700.5501.

Co-conservator

A co-conservator is a person or corporation who is serving as conservator with at least one other person or corporation. The co-conservatorship can be set up by a probate court in two different ways. The court can require the co-conservators to act upon the agreement of the co-conservators, or authorize each co-conservator to act on her or his own. To determine which, one need look at the language in the letters of conservatorship the court gives each co-conservator.

Co-guardian

A co-guardian is a person who is serving as guardian with another person. The co-guardianship can be set up by the probate court in two different ways. The court can require both co-guardianships to act only upon agreement, or

authorize each co-guardian to act on her or his own. To determine which, one need look at the language in the letters of guardianship the court gives each co-guardian.

Co-trustee

A co-trustee is a person or bank serving as trustee under a trust, when there are two or more trustees.

Conservator

A conservator is a person or corporate entity (usually a bank) appointed by a probate court to handle all or some of an individual's property and finances. To appoint a conservator for an adult, the court must find clear and convincing evidence the individual is unable to handle her or his property and finances effectively. MCL 700.5401 et eq.

Custodian

A custodian is a person who oversees money, stock or other property for an individual who is under age 21, under the Uniform Transfers to Minors Act. The property is most often money, stock or a mutual fund. Upon the individual turning 18 or 21 (depending on the terms of the document), the custodian turns the property over to the individual. MCL 554.221 et seq.

Fiduciary

A fiduciary is a general term for a relationship of trust when one person has a legal duty to follow the directions of another person, or a duty to make decisions for another in that person's best interests. Almost all the roles discussed in this fact sheet are fiduciaries.

Full guardian

A full guardian is a guardian with all possible powers a court can grant a guardian under the Estates and Protected Individuals Code. These powers include determining in what setting the individual lives; arranging and deciding upon medical treatment and non-medical services; and handling the individual's money if a conservator is not appointed. To discover whether a guardian is a full guardian, one must look at the letters of guardianship issued to the guardian by the probate court. MCL 700.5306(4).

Guardian

A guardian is a person appointed by the probate court to make health and personal care decisions (and sometimes financial decisions) for another individual. The probate court must determine by clear and convincing evidence the individual is unable to make informed decisions about her or his care, **and** that guardianship is necessary. The person may be unable to make informed decisions because of a stroke, advanced dementia, serious mental illness, a closed head injury, or any number of conditions or diseases. Estates and Individuals Code, MCL 700.5306(1).

If an individual suffers from a developmentally disability, a guardian can only be appointed for him or her under provisions of the Mental Health Code. MCL 300.1600 et seq. The definition of "developmental disability" is found at MCL 330.1100a(21).

Guardian ad litem

The role of a guardian ad litem (GAL) is of that of an investigator, making a report and recommendations to the court upon the court's appointment. A guardian ad litem is appointed in almost all guardianship proceedings. The varied responsibilities of a guardian ad litem are set forth in MCL 700.5305.

Despite the word “guardian” in the title a guardian ad litem (GAL) has no authority to make decisions for another.

Guardian of the Estate

If an individual has a developmental disability, and is unable to manage his or her property and financial affairs, a probate court can appoint a guardian of the estate under the Mental Health Code.

Guardian of the person

If an individual has a developmental disability, and lacks the capacity to do some or all tasks necessary to care for himself or herself, a court can appoint a guardianship of the person under the Michigan Mental Health Code. The duties of a guardian of the person are similar to those of a guardian under the Estates and Protected Individuals Code. MCL 300.1631.

Health care proxy

A health care proxy is another name for a patient advocate, appointed under a durable power of attorney for health care. MCL 700.5506 et seq.

Immediate family

One of a class of persons authorized to make medical treatment decisions for an individual who is terminally ill, as set forth in the Michigan Dignified Death Act. MCL 333.5653(g); MCLA 333.5655(b). The term is not defined in the law.

Limited guardian

A limited guardian is a guardian with fewer powers than all the powers that can be given a guardian under the Estates and Protected Individuals Code. MCL 700.5306(2), (3).

Limited guardianship is appropriate when an individual can make informed decisions over some aspects of her or his life and not others. For example, a limited guardian might be given authority to make medical treatment decisions, but not to determine where the individual lives. The powers of a limited guardian are set form in the court order and in the letters of guardianship issued to the guardian by the probate court. MCL 700.5306(3).

Nearest relative

If an individual is enrolled in Medicaid, and is not in a condition to make decisions for herself or himself, the individual's nearest relative is authorized to make decisions about medical treatment for the individual. MCL 400.66h. Although there is order of priority specified, one might presume spouse is first; then an adult child or adult children.

Next of kin

One of a class of persons authorized to make medical treatment decisions for an individual who is terminally ill, as set forth in the Michigan Dignified Death Act. MCL 333.5653(g); MCL 333.5655(b). Presumably, an immediate family member (see page 5) would take precedence over next of kin. There is no priority order set forth for next of kin.

Partial guardian

A partial guardian is a guardian for an individual with a developmental disability, when the guardian has fewer powers than all the powers that can be given a guardian under the Mental Health Code. MCL 330.1618(4)

The letters of guardianship should specify the powers of the partial guardian and can list the decisions the individual can still make for herself or himself. MCL 330.1620. A partial guardianship ends after 5 years (or sooner). MCL 330.1626.

Patient advocate

A patient advocate is a person chosen by an individual under a durable power of attorney for health care. The duty of the patient advocate is to make health care and personal care decisions for the individual when the individual is not able to participate in medical treatment decisions, as determined by two physicians, or a physician and a psychologist. MCL 700.5506 et seq.

Patient's Representative

A patient's representative is a person designated in writing by a nursing home resident or home for the aged resident with power to exercise certain rights of the resident referenced in statute. MCL 333.21703(2); 333.20201(5).

Patient surrogate

A patient surrogate is any person, aside from a patient advocate, who can make decisions to authorize or refuse treatment for an individual who is terminally ill and cannot participate in these decisions. A patient surrogate can be a guardian, a member of the immediate family or next of kin. Michigan Dignified Death Act. MCL 333.5653(g); 333.5655(b).

Personal representative

A personal representative is a person appointed by a probate court with a duty to administer an individual's probate estate upon the individual's death. MCL 700.1106(n). Administering the estate includes garnering the assets, paying legitimate debts, and distributing the remaining assets according to the Will (or state statute, if there is no Will). MCL 700.3701 et seq.

In a Will, an individual can nominate who she or he wishes to be her or his personal representative.

Plenary guardian

A plenary guardian is a guardian for an individual with a developmental disability, when the guardian has all the powers that can be given a guardian under the Mental Health Code. MCL 330.1618(5).

Representative payee

A representative payee is a person or organization appointed by the Social Security Administration to receive benefits for an individual unable to handle her or his financial affairs.

A representative payee has a duty to spend the funds only for the benefit of the individual, in her or his best interests, and to annually report to the government agency.

Special Conservator

If an individual meets the criteria for appointment of a conservator, but only a single transaction is needed (for example, selling a house or adding

money to a trust), a probate court can make a *protective order* and appoint a special conservator to carry out the transaction.

Standby guardian

If a probate court appoints a guardian for an individual with a developmental disability, the court can also appoint a standby guardian to serve as guardian if the initial guardian dies, becomes incapacitated or resigns (or to serve for a short period if the guardian is temporarily unavailable). MCL 330.1640.

Successor conservator

Successor guardian

Successor patient advocate

Successor personal representative

Successor trustee

Each of these five fiduciaries serves upon the first fiduciary's death, disability, removal or resignation, and has the same powers and duties as the person they replace.

Temporary guardian

A probate court can appoint a temporary guardian in two circumstances. First, if an emergency exists, a probate court – after notice to the individual and an expedited hearing – can appoint a temporary guardian for up to 28 days. A

hearing with full notice to all interested persons will then occur. MCL 700.5312(1)

Second, if a guardian is not properly performing her or his duties, a probate court can appoint a temporary guardian to replace the guardian until a court hearing to appoint a successor guardian. MCL 700.5312(2)

Testamentary guardian

If a probate court does not appoint a standby guardian, a parent who is guardian for a developmentally disabled individual may appoint, in a will, an individual to serve as guardian upon the parent's death. MCL 300.1642(2).

Under the Estates and Protected Individuals Code, a parent or spouse serving as guardian may appoint, by will or other witnessed writing, an individual to serve as guardian upon the parent or spouse's death or incapacity. MCL 700.5301(2).

Trustee

An individual (known as a *settlor*) can establish a trust effective immediately (known as an *intervivos trust*), or effective upon death (a *testamentary trust*). The individual chooses, in writing, what property to put into the trust; designates one or more beneficiaries, and appoints one or more persons or a bank (or both) to manage the property.

The person or bank the individual appoints is known a trustee. The overarching duties of a trustee are set forth in the Michigan Trust Code, MCL 700.7801-7803.

Trust Protector

A settlor can designate in a trust a person or committee empowered to direct certain specified actions during the life of the trust. Michigan Trust Code, MCL 700.7103(n). For example, a trust could provide a trust protector has power to remove a trustee. A trust protector's general duties are set forth in MCL 700.7809.

ALTERNATIVES TO CONTEMPORANEOUS DECISION-MAKING BY AN ADULT

HEALTH CARE DECISIONS

FINANCIAL DECISIONS

VOLUNTARY

Durable power of attorney for health care
a/k/a Health care proxy or Patient advocate designation

Advance directive for mental health care

Living will

Do-Not-Resuscitate declaration
(two standard forms)

Durable power of attorney (immediate or springing)

Inter vivos trust
a/k/a Living trust

Joint bank/brokerage accounts

Testamentary trust

INVOLUNTARY

Implied consent

Custom

Family consent – Medicaid

Family consent – Terminally ill

Civil commitment*

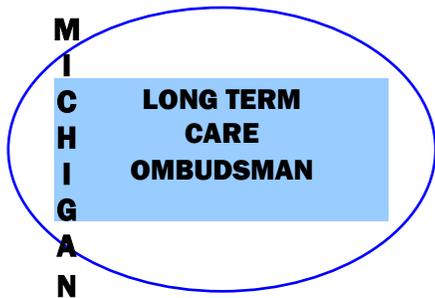
Guardianship
(temporary/limited or full)

Representative payeeship*

Conservatorship*
(full or limited)

Protective order*

* CAN BE VOLUNTARY



Fact Sheet

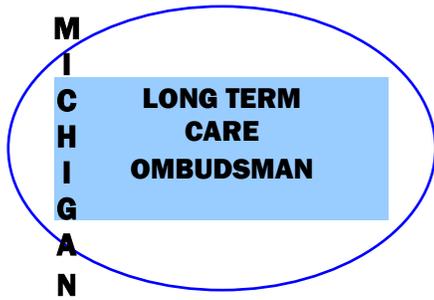
Statutory Citations for Surrogate Decision-Making

This fact sheet is a reference guide to the various methods by which a person can gain the right to make decisions for another individual.

If you need to look up the law, go to www.michigan.gov. Click on the “Michigan Government” then click on “Legislative Branch” in the drop down menu. On the right hand side of the page you will see “Quicklinks.” Click on “MI Compiled Laws.” In the box marked, “MCL Section,” type the section number of the law, e.g., 700.5505, then “enter.” The text of the law will appear.

- Durable Power of Attorney for Health Care MCL 700.5505, et seq.
- Advance Directive for Mental Health Care Michigan ... MCL 700.5515
- Do-Not-Resuscitate Declaration MCL 333.1051, et seq.
- Guardianship MCL 700.5301, et seq.
- Family consent
 - Medicaid participant MCL 400.66h
 - Individual who is terminally ill MCL 333.5652, et seq.
- Durable Power of Attorney for Finances MCL 5501, et seq.

Trust	MCL 700.7101, et seq.
Representative payee (federal law)	42 USC 401, et seq.
Protective Arrangements	MCL 700.5408
Conservatorship	MCL 700.5401 et seq.



Fact Sheet

Revocation of Advance Directives

An individual can designate another person (known as a Patient Advocate) to make medical decisions in the future if the individual becomes unable to participate in those decisions (as determined by health care professionals). The designation must be in writing in a document known as a Durable Power of Attorney for Health Care.

In the document, the individual can also provide what types of treatment he or she wishes the patient advocate to authorize or refuse.

An issue can arise concerning the circumstances when, and the procedure through which, an individual can change her or his mind.

In this discussion, we must distinguish between a durable power of attorney for health care and an advance directive for mental health care.

Durable Power of Attorney for Health Care

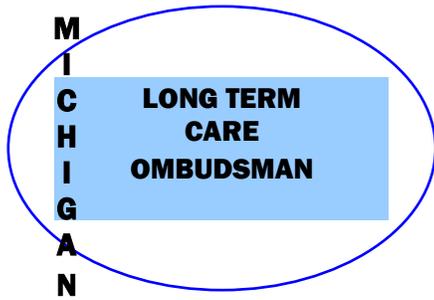
An individual can revoke a durable power of attorney for health care at any time and in any manner she or he is able to communicate an intent to revoke it. It can be oral; it can be through a shake of the head when asked the question. The right to revoke persists **REGARDLESS** of the mental state of the individual.

In order to sign a durable power of attorney one needs to be of "sound mind." One needn't be of sound mind to revoke it.

Advance Directive for Mental Health Care

An advance directive for mental health care can be different. When signing this document, an individual can CHOOSE a provision that delays revocation for 30 days after the individual communicates an intent to revoke. That is, if an individual indicates on April 1 an intent to revoke, the patient advocate would retain authority to make decisions until May 1.

If a revocation of either type of document is not in writing (there is no standard form), a person who witnesses it shall describe the circumstances in writing, and sign it. Once a health provider has notice of the revocation, the provider shall note the revocation in the individual's medical record.



Fact Sheet

When Faced with Guardianship

1. When a petition for guardianship is filed in the probate court, the court will send out a person called a *guardian ad litem* to speak with you.
2. The guardian ad litem will explain your rights and ask you questions.
3. If you have problems hearing, tell the guardian ad litem immediately.
4. If you have signed a *durable power of attorney for health care*, tell the guardian ad litem.
5. If you do not want a guardian, or you want someone other than the nominated person to be guardian, tell the guardian ad litem, and ask to have a lawyer. The court will appoint a lawyer at no cost to you.
6. Tell the guardian ad litem who you want to be guardian if the court decides to appoint a guardian. Put your wish in writing for the court.

7. Tell the guardian ad litem you want to be at the hearing. At the hearing, you can talk to the judge, and have anyone else you wish talk to the judge. If the judge asks you questions, answer them clearly.

YOUR RIGHTS IN THE GUARDIANSHIP PROCESS

**INFORMATION PRESENTED BY
THE MICHIGAN CENTER FOR LAW AND AGING
2014**

Introduction

Why am I receiving this pamphlet?

You are being provided this information because someone has asked the probate court to appoint a guardian for you;

You have a number of rights to help ensure you only have a guardian if you need one.

What is a guardian?

A guardian is a person or company appointed by a probate court to make decisions for you if there is convincing evidence you are unable to make informed decisions for yourself.

A guardian can only be appointed if necessary to provide for your care.

What decisions can a guardian make for me?

A judge can give a guardian power to decide where you live, to make medical treatment decisions for you, to arrange services and to decide how your money is spent.

Do I lose rights if a guardian is appointed?

Yes. For instance, if a guardian is given power to decide where you live, you lose the right to make that decision for yourself.

The Guardianship Petition

How is a guardian appointed?

The first step is that someone interested in your welfare files a petition in probate court.

At the same time you are receiving this pamphlet, you are being given a copy of the petition.

What is the purpose of the petition?

The petition sets forth information why the petitioner believes you need a guardian.

What happens upon a petition for guardianship being filed with the court?

Court staff set a date for a court hearing. The hearing may be very soon or a few weeks away.

The judge cannot appoint a guardian for you without a hearing.

What else happens upon a petition being filed?

Court staff will send a person to your home to talk with you before the hearing date. This person, known as a guardian ad litem, is the person who handed you this pamphlet.

The guardian ad litem has no power to make decisions for you, only to collect information.

What will the guardian ad litem talk to me about?

The guardian ad litem will explain guardianship and your rights in the process, and determine whether you object to guardianship, want limits on the guardian's powers, or have a specific person you want to serve as guardian.

The guardian must also talk to you about whether you want to be resuscitated if your breathing and heart stop.

What if I have signed a durable power of attorney for health care in the past?

Make sure you make the guardian ad litem aware of the document. Give him or a copy of the document if you have one.

The court cannot give a guardian powers that your patient advocate has, if your patient advocate is properly performing.

Your Rights

Can I choose the person to be my guardian?

Yes, you have this right, and the court must honor your choice if the person you choose is suitable and willing to serve. Tell the guardian ad litem of your choice.

If I do not want a guardian, what do I do?

It is very important you tell the guardian ad litem if you do not want a guardian, or if you do not want a particular person to serve as guardian, or if you want the guardian's powers limited in any way.

By law, the guardian ad litem must report your wishes to the court, and court staff must appoint a lawyer to represent you.

Can I hire my own lawyer instead of having the court appoint a lawyer?

Yes. You also always have the right to hire a lawyer.

What is the role of my lawyer?

Whether the lawyer is court appointed or chosen by you, your lawyer must strongly argue for your wishes, regardless of what anyone else thinks is best for you.

Do I have the right to get a professional evaluation of my ability to make decisions?

Yes. You can choose a doctor, psychologist, nurse or social worker to do the evaluation. If you cannot afford the cost of the evaluation, the court will pay for it.

The Court Hearing

What is the purpose of the court hearing?

The person who filed the petition must present evidence and prove that you cannot make informed decisions for yourself, and that guardianship is necessary to meet your needs.

Do I have the right to attend the court hearing?

Yes, you always have the right to be at the hearing.

Tell the guardian ad litem if you want to attend the court hearing. Tell the guardian ad litem if you need transportation to get to the hearing, and if you need any help such as a wheelchair, a special hearing device or an interpreter in the courtroom.

What if I disagree with the evidence presented?

You or your lawyer have a right to dispute any evidence presented, and you or your lawyer has a right to present witnesses and other evidence on your behalf.

Who decides whether I need a guardian?

The judge will make the decision whether there is clear and convincing evidence you cannot make informed decisions over one or more areas of your life. The judge will also determine whether guardianship is necessary to meet your needs.

Do all guardians have the same powers?

No. For example, a judge might grant a guardian power to make medical decisions for you, but not the power to decide where you live or to handle your money.

The judge will determine what powers the guardian will have, based on your needs.

How do I know what powers my guardian has?

The court order signed by the judge, and the letters of guardianship given to the guardian, must show the powers the guardian has.

You can ask court staff or the guardian for a copy of the letters of guardianship

After a Guardian is Appointed

What are some responsibilities of a guardian if one is appointed for me?

Your guardian is required to visit you at least every three months, and to talk with you before making major decisions.

Your guardian is required to make decisions in your best interests, and to arrange appropriate medical, housing and social services so you can regain as much self-care as is possible.

If I have a guardian, do I lose all my rights?

No. For example, generally you maintain the right to speak your mind, to practice your religion and to see family and friends of your choice.

Can a guardian sign a do-not-resuscitate order for me?

A court can give a guardian this power. But you always have the right to revoke the do-not-resuscitate document.

If I object to any of the guardian's decisions, what can I do?

You can write a letter to the probate judge, or you can file a petition with the court. There is no cost. You can ask the judge to -

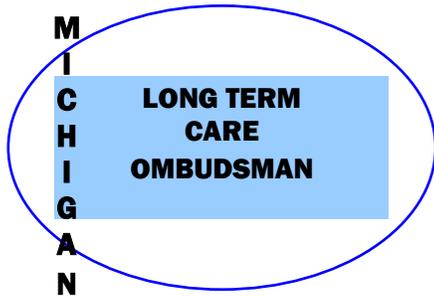
- End the guardianship, or
- Limit the guardian's powers, or
- Name another person as guardian.

Can I hire a lawyer to represent me?

Yes. If you do not hire a lawyer, request the judge appoint one for you. The judge is required to do so.

Will there be another court hearing?

Yes. You have all the same rights you had during the first hearing.



Fact Sheet

Guardianship and Nursing Home Residency

What Rights Does a Resident Retain?

Guardianship is imposed upon an individual, by a probate court, after notice and a hearing. The petitioner must prove two things: the individual is not capable of making informed decisions **and** guardianship is necessary.

A guardianship may be a full guardianship or a limited guardianship. In a limited guardianship, the specific powers of the guardian will be set out in the court Order and in the Letters of Guardianship, given the guardian.

Michigan law provides a full guardian can decide where the individual lives, and is responsible for arranging for the care, comfort and maintenance of the individual. The guardian must take care of the individual's personal property, and if a conservator is not appointed, has power to handle income and assets.

Federal and state law provides an extensive list of rights for residents of nursing homes.

Federal law provides if a resident has a guardian, the resident's rights are exercised by the guardian. If the guardianship includes the power to make medical decisions, it is the guardian, and not the resident, who authorizes or refuses treatment. Although a resident ordinarily has the right to leave the care of the nursing home and return home, a guardian can pre-empt that right.

There is nothing in Federal or state law that addresses which rights the guardian may **refuse** to honor.

We can assume there are rights a resident retains under guardianship, and other rights a court can take away, but only upon a specific finding during a court hearing.

Some important rights a resident always retains –

- Freedom of speech and religion
- Freedom from chemical and physical restraints except as medically necessary
- Right to complain to the nursing home, Bureau of Health Systems and the ombudsman program about any care or treatment issue
- Right to request the probate court to terminate guardianship, limit the guardian's powers or appoint of a different guardian.
- Right to hire a lawyer

Rights an individual likely retains under guardianship, unless probate court explicitly restricts them.

- Having visitors of one's choice

- Using telephone privately, and sending and receiving mail unopened
- Participate in activities

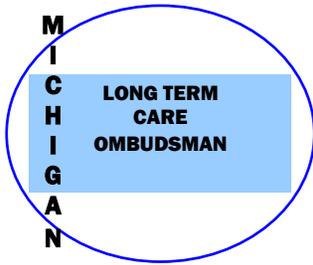
There are two further provisions of Michigan law worth considering. First, if communication is possible, a guardian has a duty to consult with an individual before making a major decision.

Second, a guardian has a duty to arrange services to restore the individual to the best state of mental and physical well-being possible, so that the individual can return to self-management. The spirit of the law is to further the independence of the individual, consonant with an individual exercising her or his rights.

What if guardian is not respecting an individual's rights?

Talk with the guardian, and try gentle persuasion. Offer mediation, which may be available for free from a community dispute resolution agency. Inform the individual of her or his right to go to probate court. There is no filing fee, and the individual can begin the process with a letter to the probate court judge.

For more information, please call our toll free number: **1-866-485-9393**



Fact Sheet

Modifying A Guardianship

An adult who has a guardian appointed under the Estates and Protected Individuals Code has the right to request the probate court change the guardianship. It does not matter whether the guardianship is full or limited.

There is one narrow exception: a court can restrict this right for a time period not to exceed 182 days after the guardianship is established. MCL 700.5310(3). Few court orders contain this restriction.

An individual may request the court modify the powers of the guardian, appoint a different person as guardian, or terminate the guardianship.

The request may be accomplished in two ways - by filing a petition, or by mailing an informal letter to the court or to the judge. The petition or letter can be completed by the individual or by anyone interested in her or his welfare. No one - including the guardian - is permitted to interfere with the sending of the informal letter. MCL 700.5310(2).

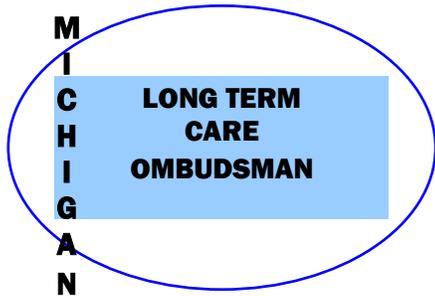
The form number for the petition is p 627.

When the court receives a letter or petition, the court will set a hearing date. The court might appoint an attorney to represent the individual; the court might instead appoint a guardian ad litem to do an investigation.

In reality, the burden is on individual to show changed circumstances (or that a mistake was made initially), if he or she wants limits on the guardianship or the guardianship terminated. It is very helpful to present a doctor's statement or other medical evidence.

If the individual wants a different guardian, courts differ on the standard. Some courts will follow the law for initial appointments - first priority is to someone chosen by the individual (assuming that person is willing and able to serve). Other courts will require proof the guardian is not fulfilling his or her duties or there are changed circumstances. It will be helpful for the individual to have witnesses.

It is not easy for an individual to succeed in changing the terms of a guardianship, except if the guardian agrees.



Fact Sheet

Mediation in Care-Giving Disputes

Mediation is a process in which people meet privately to work out a solution to their problem with the help of a neutral party (mediator). Unlike an administrative or courtroom hearing, where a hearing officer or judge decides what facts are important and decides what should happen, a mediator helps the parties themselves decide what is important and propose their own solutions to resolve the problems. If successful, mediation results in a written agreement acceptable to all parties.

Mediation is used increasingly to resolve care-giving disputes, whether in the community or in nursing facilities, homes for the aged, or adult foster care. Mediation can be set up quickly. Mediation is confidential. Mediation costs very little. Mediation does not require attorneys. Mediation can include as many interested parties as necessary, unlike an administrative or court hearing where generally only two sides can participate. Mediation allows participants to explore underlying issues and problems affecting the specific issue, which led to mediation.

Mediators who work on these types of disputes are specially trained to encourage participation by the older or disabled adult and to help the person express their issues and proposed solutions. Sometimes the mediator must arrange for another person to help the disabled or older adult participate at whatever level is possible. In some cases, an advocate would represent the interests of the person when the person could not or chose not to participate.

What kinds of issues can be mediated?

- Daily care-giving issues
- Family/staff issues
- Communication issues
- Health/medical care/end of life decisions
- Safety/risk-taking/autonomy
- Access/visitors
- Financial decisions
- Family relationship issues

For more information please call our toll free number:

1-866-485-9393

Community Dispute Resolution Programs Offering Mediation

Berrien, Branch, Cass, St. Joseph, Van Buren Counties:

Citizens Mediation Services, Inc.
2800 Cleveland Ave., Ste. 2
St. Joseph, MI 49085
269-982-7898
Fax - 269-982-7899
e-mail - matt_balfe@citizensmediation.org
web – www.citizensmediation.org

Charlevoix and Emmet Counties:

Citizen Dispute Resolution Services, Inc.
Northern Community Mediation
415 State Street
Petoskey, MI 49770
231-487-1771
Fax – 231-487-1770
e-mail – Jane@NorthernMediation.org

Chippewa, Luce, Mackinac Counties:

Eastern UP Dispute Resolution Center, Inc.
(LSSU Brown Hall, Office #2)
PO Box 505
Sault Ste Marie, MI 49783
906-632-5467
Fax – 906-632-5471
e-mail – cdrc@30below.com

Delta, Menominee, Schoolcraft Counties:

Resolution Services Program, UPCAP Services, Inc.

PO Box 606 (2501 14th Ave. S)

Escanaba, MI 49829

906-789-9580

Fax – 906-786-5853

e-mail – gocc@charterinternet.com

web – www.upcapservices.com/other-resoservices.shtml

Genesee, Arenac, Bay, Clare, Gladwin, Midland, Ogemaw, Roscommon Counties:

Community Dispute Resolution Center of Genesee County, Inc.

315 E. Court St., Ste. 200

Flint, MI 48502

810-249-2619

Fax - 810-239-9545

e-mail – crcdayna@sbcglobal.net

Gogebic, Baraga, Dickinson, Houghton, Iron, Keweenaw, Ontonagon Counties:

Western UP Mediators

115 E. Ayer St.

Ironwood, MI 49938

906-932-0010

Fax – 906-932-0033

e-mail – mediator@up.net

Grand Traverse, Benzie, Leelanau, Missaukee, Wexford Counties:

Community Reconciliation Services, Inc.

1022 E. Front Street

PO Box 1035

Traverse City, MI 49685-1035

321-941-5835

Fax – 321-941-4530

e-mail – CRService@thirdlevel.org

Ingham, Clinton, Eaton, Gratiot, Ionia, Shiawassee Counties:

DRCCM-Dispute Resolution Center of Central Michigan

2929 Covington, Ste. 201

Lansing, MI 48912

517-485-2274

Fax – 517-485-1183

e-mail – drccm.beauregard@tds.net

Jackson, Hillsdale, Lenawee, Monroe Counties:

Southeastern Dispute Resolution Services

Community Action Agency

1214 Greenwood

PO Drawer 1107

Jackson, MI 49204

517-784-4800

Fax – 517-784-5188

e-mail – mstanley@caajlh.org

Kalamazoo, Barry, Calhoun Counties:

Dispute Resolution Services

Gryphon Place

1104 S. Westnedge Ave.

Kalamazoo, MI 49008

269-552-3434

Fax – 269-381-0935

e-mail – bburnside@gryphon.org

Kent, Isabella, Lake, Mecosta, Montcalm, Newaygo, Osceola

Dispute Resolution Center of West Michigan

Community Reconciliation Center

678 Front St., NW, Ste. 250

Grand Rapids, MI 49504

616-774-0121

Fax – 616-774-0323

e-mail – drcwestmich@hotmail.com

web – www.drcwmich.org

Macomb and St. Clair Counties

The Resolution Center
176 S. Main St., Ste. 2
Mt. Clemens, MI 48043
586-469-4714
Fax – 586-469-0078
e-mail – theresolutioncenter@mediate.com
web – www.theresolutioncenter.com

Marquette and Alger Counties:

Marquette-Alger Resolution Services
MSU Extension
184 US Hwy 41 E
Negaunee, MI 49886
906-475-5739
Fax – 906-475-4940
e-mail – marsmediation@yahoo.com
web – www.marsmediation.org

Muskegon, Manistee, Mason, Oceana Counties:

Westshore Dispute Resolution Center
8 W. Walton Avenue
Muskegon, MI 49440
231-727-6001
Fax 231-727-6011
e-mail – wdrc@verizon.net

Oakland County:

Oakland Mediation Center, Inc.
850 Hulet Drive, Ste. 102
Bloomfield Hills, MI 48302
248-338-4280
Fax – 248-338-0480
e-mail – bhanes@mediation-omc.org
web – www.mediation-omc.org

**Otsego, Alcona, Alpena, Antrim, Cheboygan, Crawford, Iosco, Kalkaska,
Montmorency, and Presque Isle Counties:**

Community Mediation Services
Otsego County Michigan State University Extension Services
United Way Bldg.
116 5th Street
Gaylord, MI 49735
989-732-1576 or 989-705-1277
Fax 989-705-1337
e-mail – mediation@voyager.net

Ottawa and Allegan Counties:

Center for Dispute Resolution
Macatawa Resouce Center
665 136th Ave.
Holland, MI 49424
616-399-1600
Fax – 616-399-1090
e-mail – cdrexec@macatawa.org
web – www.centerfordisputeresolution.org

Tuscola, Huron, Lapeer, Sanilac Counties

Center for Dispute Resolution
Human Development Commission
429 Montague Ave.
Caro, MI 48723-1997
989-672-4044
Fax – 989-673-2031
e-mail – peggyd@hdc-caro.org

Washtenaw and Livingston Counties

Dispute Resolution Centers of Michigan, Inc.

The Dispute Resolution Center

110 N. Fourth Ave. Ste. 100

PO Box 8645

Ann Arbor, MI 48107-8645

734-222-3745

Fax 734-222-3760

e-mail – langk@washtenaw.org

web – www.mimmediation.org

Wayne County

Neighborhood Reconciliation Center

Garrison Place

19855 W. Outer Drive, Suite 206, East Bldg.

Dearborn, MI 48124

313-561-3500

Fax 313-561-3600

e-mail – hlischeron@mediation-wayne.org

web – www.mediation-wayne.org