

## **Chapter 5**

# **Equipping California Long-Term Care Ombudsman Representatives for Effective Advocacy: A Basic Curriculum**

## **RESIDENTS' RIGHTS TEACHING NOTES**

Curriculum Resource Material for  
Local Long-Term Care Ombudsman Programs

**Developed by Sara S. Hunt, Consultant**

### **Office of the Long-Term Care Ombudsman Program**

California Department of Aging  
1300 National Drive, Suite 200  
Sacramento, California 95834  
Telephone: (916) 419-7510

[www.aging.ca.gov](http://www.aging.ca.gov)  
[stateomb@aging.ca.gov](mailto:stateomb@aging.ca.gov)

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**Symbol Legend**

-  = Handout
-  = Video/CD
-  = Key teaching concepts

## RESIDENTS' RIGHTS CURRICULUM CHAPTER

### TEACHING NOTES



### INTRODUCTION

#### PURPOSE

This chapter provides an understanding of the federal nursing home residents' rights as well as residents' rights provisions in California laws and regulations covering Skilled Nursing Facilities (SNFs) and the role of Long-Term Care Ombudsman representatives (LTCO) in supporting residents in exercising their rights. Only State information on residents' rights in Residential Care Facilities for the Elderly (RCFEs) is included due to the lack of a federal law or regulations. The presumption is that understanding how to think about residents' rights will equip LTCO to advocate on behalf of all residents regardless of the long-term care (LTC) setting.

#### LEARNING OBJECTIVES

At the conclusion of this chapter, individuals will know:

- the principles underlying residents' rights;
- specific residents' rights provisions;
- how residents can be encouraged and supported in exercising their rights;
- the role of LTCO.

#### BASIS FOR APPROACH

This chapter assumes that if the LTCO understands the basic concepts that are the foundation of all residents' rights, they will be equipped to identify, support, and think broadly about accommodating the more specific provisions of rights. One key to being an effective resident advocate is to understand how the concepts underlying residents' rights are basic to each of us in everyday life. Therefore, this chapter begins by pointing to a few very important concepts for LTCO to understand on a personal level and to retain to guide their work. By reading, reviewing, talking with others, and resolving complaints, LTCO will learn the specific list of rights.

The teaching outline and notes are intended to be interactive and application based. While the Residents' Rights Curriculum Resource Material contains a section on empowerment as an Ombudsman approach, the teaching notes do not include a specific section on empowerment. Trainees need to read the resource material, and **the instructor needs to incorporate Ombudsman empowerment into the case application and discussion throughout the session.**

Other tools such as the Nursing Home Reform Law, federal and State requirements, and care planning, are introduced as they relate to residents' rights. This teaching outline does not attempt to include a full discussion of these topics. The purpose of including these tools in this curriculum chapter is to show their direct application to residents' rights for beginning LTCO. More content and assistance will be needed at a

later time. The focus in this chapter is introductory and immediately relevant to residents' rights. This is beginning training, not designed to impart everything LTCO will eventually need to know about this topic during one session.

## CONTENTS

### This chapter contains:

- an agenda,
- a teaching outline,
- handouts ,
- PowerPoint presentations, and
- narrative resource material that is the basis for this teaching chapter.

This chapter uses two videos/CDs which previously were distributed to all State Long-Term Care Ombudsman Programs.:

-  *Basic Complaint Handling Skills for Ombudsman*, by the National Long-Term Care Ombudsman Resource Center (NORC). This is included on the curriculum CD distributed by the Office of the State Long-Term Care Ombudsman (OSLTCO). If additional copies are needed, contact the OSLTCO.
-  *Nursing Home Care Plans: Getting Good Care*, by the AARP. To obtain a free copy, contact AARP Fulfillment, 601 E Street, NW, Washington, DC 20049, Stock #: C1642.

## OPTIONS FOR TEACHING

There are various ways to cover this content. Because this chapter is designed to be integrated with the other chapters in this curriculum, it builds upon information previously covered and sets the stage for exercises to be used in successive chapters. The recommended teaching option is combined self-study and classroom learning.

- **Combination of Self-Study and Classroom:** Individuals read the resource material prior to attending a class. The classroom session applies that content to daily life, to interactions with residents, and uses case examples to show the role of the LTCO. Any questions trainees have can be addressed and additional information and resources are introduced. By reading the resource material prior to class, trainees attend with an introduction to the content which minimizes the need for lecture. This method lets the class be much more interactive with a focus on application and reinforcement of key points. The Teaching Outline is designed for use in a classroom setting.
- **Individualized Training:** The preferred training method is the classroom setting with a group of new trainee volunteers. At times, local Ombudsman Coordinator may provide 36 hours of individualized training sessions to a potential LTCO depending on the needs of the Program. Modify the teaching outline to cover or adapt the exercises for use in a one-on-one situation.

## TEACHING TIPS

### Focus

- Remember that new LTCOs need to absorb the underlying premise of residents' rights. They need to learn how to identify and approach residents' rights issues and their role in modeling respect for each resident's rights.
- Focus discussion, additional case studies, handouts, and your response to questions on the basics. Defer more complicated issues until a continuing education training session or suggest an individual discussion to avoid overwhelming other trainees.
- Be mindful of the time available for classroom work and the content that must be covered. Because residents' rights is such an important topic and is filled with interesting examples, it usually prompts a number of questions and sharing of personal experiences. It is easy to spend too much time on one or two aspects without covering the foundation of knowledge that is essential for new LTCOs.

### Adapt

- Adapt the teaching outline to fit the needs of your Program and the individuals you will be training.
- If you do not use the PowerPoint presentations, print the slides and use those as handouts and/or overhead transparencies.
- If needed, add additional content on RCFE residents' rights and point out that there are no federally guaranteed rights in these settings. Residents retain all of their civil rights as if they lived in their own homes. Mention typical rights issues that arise as appropriate for this initial training.

### Prepare

- Read the curriculum resource materials, "Residents' Rights."
- Read the Teaching Outline, decide what exercises you will use, make your notes and add to the list of supplies in the following section.
- Where indicated in the outline by ►, have additional materials ready to use.
- View the video/CD, walk through the PowerPoint presentations, and read all of the handouts to spot areas you may want to adapt or supplement. Decide which ones you will use, how you will use them, how much discussion you want to generate, and other teaching points you want to add to have an estimate on how much time each presentation will take.
- Adjust the time frames according to variables such as the number of trainees, the pre-class knowledge of trainees about the LTCOP, amount of discussion or questions you expect, and the teaching points you want to make.

- Invite one or two experienced LTCO to participate in part of the day as suggested in the teaching outline. Be specific about their role and the amount of time allotted to this section of content prior to the session.

**Supplies you will need:**

- Videos/CDs 
  - *Basic Complaint Handling Skills for Ombudsman*, National Long-Term Care Ombudsman Resource Center<sup>1</sup>
  - *Nursing Home Care Plans: Getting Good Care*<sup>2</sup>
- PowerPoint presentations,
  - Individualized Care Supported by Law
  - Intersection of Rights and Care: Care Planning
- Copies of handouts :
  - Federal residents' rights requirements and provisions of the Nursing Home Reform Law. If trainees have the curriculum resource material with them, these documents are contained in the Appendices. They are not duplicated in these teaching notes.
  - ▶ Excerpt from the California Code of Regulations for Skilled Nursing Facilities (SNFs). This is included as a handout in Appendix B. The complete listing of residents' rights for SNFs and for RCFEs is also included in the Appendix. If you want to use additional provisions, you will need to adjust the handout or use the material in the curriculum resource module.
  - Appendix A
    - Daily Routines and Preferences
    - *Case Notes: Mrs. Woods, Analysis of Law and Regulations*. It is helpful to have this handout as a hard copy handout as well as on an overhead transparency or as a document or slide that can be projected during discussion. ▶ Customize this handout, using a different form or format if necessary
    - *Assessment and Care Planning: The Key to Good Care*
    - Cases and Care Plan Examples
    - Guardians, a role play

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<sup>1</sup> Distributed by the OSLTCO on the CD with this curriculum

<sup>2</sup> Available from AARP

○ Appendix B

- Excerpts from *The Guidance to Surveyors, Quality of Life and Residents' Rights*
  - Excerpts from *The Guidance to Surveyors, Quality of Care*
  - Excerpt from *California Code of Regulations, Skilled Nursing Facilities*
- Flip chart and markers, chalk board, white board, blank transparencies and pens or some other medium to write upon
- Pens or pencils, highlighters
- Audiovisual equipment for CD, video, cassette, PowerPoint presentations, and/or overhead projector and screen
- Background music recording (optional)

# RESIDENTS' RIGHTS FOR LONG-TERM CARE OMBUDSMAN REPRESENTATIVES

## PROPOSED AGENDA

This agenda is suggested for classroom use and is based on the recommended activities contained in the Teaching Outline. The time frames do not include the optional activities that are included in the Teaching Outline. To use these activities, some adjustment in the agenda times might be required.

It is possible to teach this content in two segments if a four-to-six hour segment is not available.

15	minutes	Introductions and Purpose of the Training
1	hour	Introduction to Residents' Rights
1 – 2	hours	Legal Support for Residents' Rights
45	minutes	Intersection of Residents' Rights and Individualized Care
1	hour	Focus on Selected Residents' Rights
15 – 30	minutes	Other Resources
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4.25 – 6	hours	Total time <u>without</u> time for breaks

## TEACHING OUTLINE

### TEACHING NOTES

### YOUR NOTES

#### Purpose

This chapter provides an understanding of residents' rights and the role of LTCO.

#### Learning Objectives

At the conclusion of this chapter, individuals will know:

- the principles underlying residents' rights;
- specific residents' rights provisions;
- how residents can be encouraged and supported in exercising their rights;
- the role of LTCO.

#### I. Introduction to Residents' Rights

*(One hour, depending upon the amount of pre-class LTCOP knowledge by trainees, number of trainees, and issues raised.)*

- A.** Inform trainees that you are going to give them a mental break from learning about the LTCO role and let them have some personal time to focus on themselves. Ask them to put aside their professional or "LTCO trainee" mindset and think about their own needs and desires for a few minutes. *Consider playing some background music at the beginning of this session and through the individual portion of the first exercise to set the tone and help trainees mentally shift gears.*
- B.**  Distribute the handout, *Daily Routines and Preferences*. Ask the trainees to complete this handout as an individual exercise. Assure them that the handout will not be turned in so they can be honest. Ask them to jot down notes without worrying about spelling or sentence structure. Allow 5 – 10 minutes for completing the handout.
1. Ask trainees to compare their routines in questions #1 and #3 with a classroom neighbor's routines. (5 – 7 minutes)
  2. Ask, "Did any of you find an exact match with your neighbor's routines?" "Would the two of you be compatible roommates?"

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3. "Did you learn that you have more daily routines than you thought you did?"
4. Ask the group to share their responses to question #5. Write their answers on the flipchart. Typical responses include: grouchy, withdrawn, depressed, angry, moody, irritable. If necessary, probe until trainees honestly share feelings and reactions. For example, if someone says she "goes with the flow," ask if there is a limit to that or if she acts like she is taking things in stride while biting her tongue or asking herself, "How much longer will this continue?" If someone says he becomes "irritated," ask "How do you express that?" (specific body language, specific words, voice tone?) Stay focused on the individuals in their current, daily life; avoid letting their responses prematurely move into the next question.
5. Briefly review the responses listed on the flipchart.
  - Ask, "If you were a nursing facility resident and had these reactions or behaviors, what would staff say about you?" "How would you be labeled?" List the responses to these questions.
  - Ask, "Would it be easy to find staff to work with you?" "How would most staff approach you if they had heard about your behavior or attitude?"
  - Would anything be said about you, or done, if you were in an RCFE and had these behaviors? Briefly discuss responses, pointing out a few differences in nursing facilities and RCFEs.
6. Ask the group to share their responses to question #6. Typical responses include: "Let me sleep until I'm ready to awaken"; "Let me go to sleep listening to The Late Show"; "Ask me before you move any of my things"; or "I need some private, quiet time every day." Write these on another flipchart page. Push trainees to be specific instead of accepting general comments like, "need to know me."
  - Review the responses, grouping them into big categories such as choice, control, decision-making, participation.

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- Ask, “Which of your responses would be impossible to accommodate?” In fielding this discussion, draw upon your knowledge of individualized care practices, good provider practices such as the Pioneer Network practices [www.pioneernetwork.net](http://www.pioneernetwork.net) or Lumetra [www.lumetra.com](http://www.lumetra.com). Be prepared to push trainees’ thinking beyond what they typically see or expect in nursing facilities.
- Conclude this activity by reviewing the exercise and information on the flipchart pages. Consider making another chart as you review with columns such as, “Emotional Reaction/Behavior,” “Probable Label,” “What the LTC facility should know.” **Tip: Prepare flipchart page(s) with these headings ahead of time.**

### ⇒ Key points:

- Each of us has individual routines and preferences. Most of these can be distilled to exercising choice, control, and decision-making over our schedule and **basic** daily functions.
- When these are continually disrupted or not respected, we become less than pleasant.
- Avoiding these negative behaviors or attitudes is simple—respect our individuality, maintain typical order in our daily life. If this occurs, most of us are more responsive to others.
- The basic principles each of us wants, *choice, control, decision-making, and participation*, are the foundation of the federal residents’ rights.

While visiting residents as the LTCO, instead of concentrating on the specific list of legal rights, think in terms of supporting individual choice, control, decision-making, and participation. Think about the *basis* for the list of rights.

## YOUR NOTES

**TEACHING NOTES****YOUR NOTES****II. Legal Support for Choice, Control, Decision-Making, and Participation—Residents' Rights****A. Case Example: Mrs. Woods**

 The following notes assume that trainees have been introduced to Mrs. Woods in the video/CD, *Basic Complaint Handling Skills for Ombudsman*, and have discussed Ombudsman techniques in a prior curriculum chapter. If this has not occurred, more time and discussion will be required before following this outline section, or skip this exercise.

1. Ask participants to recall the initial dialogue between Mary and Mrs. Woods.
  - “What were some of the things Mrs. Woods said that were problems or areas of dissatisfaction?” It might be helpful to replay the segment of the video, vignette 1, when Mary is reflecting back to Mrs. Woods what Mary heard. List these.
  - “How do the items Mrs. Woods mentioned relate to the exercise we just completed on our routines and preferences?”
  - “If Mrs. Woods were to have several of the things she mentioned, what changes might you expect to see in her daily life?”
  
2. What Mrs. Woods said she would like to have is supported by federal law and regulations (requirements).
  -  “Let’s see what Mary thought might be helpful in addressing Mrs. Woods’ concerns.” Use the handout, *Case Notes: Mrs. Woods, Analysis of Law and Regulations*. This analysis focuses only on the coffee issue, not every concern that Mrs. Woods mentioned. If you have already used this for another exercise, ask trainees to refer to it. If you have not introduced the documentation on Mrs. Woods’ case, distribute the *Mrs. Woods: Intake Summary* page to recap the issues and to identify the case. You might also prepare the handout as an overhead.
    - Ask, “Why would LTCO read the law and regulations before moving ahead with investigation?” Briefly explain when an analysis is needed before taking additional

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action. Not every case will require a detailed review of the law and regulations in the beginning. Over time, LTCO will know many of the key provisions. A few ideas are to:

- learn what applies to specific issues and how specific the provisions are,
- gather ideas for interview questions,
- gather more ideas for what you want to observe pertinent to the concern,
- gain ideas regarding what the facility is expected to do.

An analysis might *not* be needed when the issue relates to a residents' right or to another provision that the LTCO knows and the resolution is expected to be relatively easy. For example, a resident's call light has not been answered for fifteen minutes. The resident asks the LTCO to ask someone to come to her room. The staff is apologetic and responds immediately. In talking with other residents in the facility, the LTCO gathers information about staff responsiveness to call lights as well as making independent observations.

- Look at Mary's *Analysis of Law and Regulation*. ► Add additional laws and regulations to the handout and to the other materials if appropriate.
  - Provide a few minutes for trainees to read the handout.
  - Briefly explain that the federal law was enacted by the U. S. Congress, the Medicaid/Medicare Requirements were developed to interpret the federal law. The requirements are the standards that all facilities receiving Medicare or Medicaid (Medi-Cal) funds must meet.
  - Briefly explain that California's laws and regulations for nursing facilities cannot reduce the federal provisions but can exceed them. Give the names of California's laws and regulations for SNFs and for RCFEs, (California Welfare and Institutions Code; California Code of

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Regulations). Residents' rights provisions for SNFs and for RCFEs are in the Appendix of the "Residents' Rights Curriculum Resource Material."

-  Guide trainees in looking at excerpts from the source documents where Mary found these provisions. Use the three handouts,
  - *Federal Law—Regulation of Nursing Facilities*, included in the curriculum resource material,
  - *Guidance to Surveyors, Excerpts on Quality of Care (QoC) and Care Plans*, and
  - *Guidance to Surveyors, Excerpt on Quality of Life (QoL), Selected Residents' Rights, and Dietary*.
  - For the *Guidance to Surveyors*, explain how to use or interpret the information in the handout. For reference purposes the federal survey "tag" number is the "F" number. Each F Tag corresponds to a federal requirement for nursing facilities. The federal requirement (regulation) that essentially restates the federal law follows the section symbol such as, §483.10. The "Interpretive Guidelines" and following sub-sections describe how to determine whether a facility is complying with the requirement. This information explains what facilities can do to meet the requirements.
  - Reassure trainees that they do not need to understand every term or process included in these handouts. You might explain and write on flip chart what MDS (Minimum Data Set) and RAPs (Resident Assessment Protocols) stand for without going into great detail.
  - *California Code of Regulations: Excerpt from resident's rights for skilled nursing facilities*
  - Direct trainees to the sections in each handout that correspond to the provisions Mary listed.
  - Ask different individuals to read aloud

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the provisions.

- Ask for comments or ask how each provision could be used to support something specific that Mrs. Woods mentioned.
- Summarize by pointing out how these provisions support Mrs. Woods in exercising choice, control, decision-making and participation in her daily life.

**B. Alternative or Additional Exercise to Case Example A in Section II, A: Mrs. Woods.**

1. Use your own case study that is clear and focuses on a few issues regarding accommodation of individual needs and preferences.
2. Follow the suggestions for the Mrs. Woods case analysis of law and regulations to work through your case.

**C. Individualized Care Supported by Federal Law**

Skip any of the following points that were included in previous discussion. This is another section that may be adjusted according to the time allocated for this topic. If you prefer, use the PowerPoint presentation, *Individualized Care Supported by Law*, to move through the key points. Speaking notes are not included with the presentation because the slides closely follow the points in these notes. The presentation is included as an option for interjecting visual interest and reinforcing key concepts.

1.  There are two major provisions that are the building blocks in the federal Nursing Home Reform Law (Omnibus Reconciliation Act (OBRA) of 1987). Refer back to the two handouts, Excerpts from *The Guidance to Surveyors*, and write points on a flipchart as you discuss each one.
  - Quality of Care (QoC): Read, pointing out individual resident language.
    - Ask, “What does this provision mean in everyday terms? How would you explain this to a resident?” Briefly discuss.

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- Quality of Life (QoL): Read and briefly discuss meaning, pointing out each resident language.
    - Ask, “What does this provision mean in everyday terms? How would you explain this to a resident?” Briefly discuss.
    - Manner = approach, way, attitude
    - Environment = surroundings
  - Ask, “What are these two provisions directing the facility to do relative to the routines and preferences of each resident?” (Support the routines and preferences of each individual resident in providing care.)
- 2. Optional activity** to extend and reinforce the teaching points, depending upon available time. Use creativity and interaction in examining these handouts and in making the teaching points. A few ideas are:
- Divide into small groups and assign the QoC and the QoL excerpts to different groups.
    - Consider breaking the QoL handout into subsections for assignments such as “dignity,” “self-determination,” “participation in other activities,” “accommodation of needs”.
    - Ask each group to read, discuss, and report on specific ways that the excerpt supports upholding their individual routines and preferences as discussed in the previous exercise, *Daily Routines and Preferences*.
  - Assign the QoC and the QoL excerpts to different individuals. Ask everyone to read their excerpt and highlight provisions that support individualized care, routines, and preferences. *Be sure everyone has a highlighter.* Conclude by asking trainees to read some of the provisions/words they highlighted.
  - With either of these or with another approach, pull the group into a general discussion to share information with everyone.
    - Ask for ideas about why residents’ rights are included under the Quality of Life section.

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Discuss briefly.

- As appropriate, relate some of the statements and discussion back to the information on the flip chart pages from the preceding exercise on routines and preferences. Point out how some of the provisions being discussed relate to what was said about what facilities would need to know or to the points about what is important to individuals.
- Summarize the key teaching points.

➔ **Key points:**

- The federal law reinforces the facility's responsibility to use individual approaches that support each person's routines and preferences.
- A required part of the resident assessment mentioned in the excerpts is basic information on the individual's customary routines. The areas covered include bathing, visitors, staying up late, snacking during the day, and being outside — key elements each of us identified as important in our daily lives.
- Based on a review of just a few of the legal provisions, it is obvious that the law supports an individual's ability to exercise choice, control, and decision-making, over his/her schedule and **basic** daily functions.

The law supports the importance of individual routines and preferences in many ways. The residents' rights provisions are just one example of how this is reiterated in the law.

### **III. The Intersection of Residents' Rights and Individualized Care (Forty-Five minutes)**

Skip or modify any of the following sections that were discussed during the preceding exercise that highlighted provisions supporting choice, control, decision-making, and participation. More in-depth training on care planning and how to use it as an advocacy tool may be included in a continuing education training session at a later time. The purpose of this section is to introduce these concepts as a way for residents to exercise their rights and for

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LTCO to support residents. Keep this discussion on an introductory level, defer more detailed questions and teaching for another session.

**A.** Care planning is intended to be a forum for individualizing care. If you wish, use the PowerPoint presentation, *Intersection of Rights and Individualized Care: Care Planning*, to move through the key points. Speaking notes are not included with the presentation because the slides closely follow the points in these notes. The presentation is included as an option for interjecting visual interest and reinforcing key concepts.

1.  Examine the care plan information on the handout, *Excerpt from the Guidance to Surveyors, QoC*.
  - Point out the probes for surveyor questions, especially the ones dealing with resident and family participation and the timing of care plan meetings.
  - Point out key aspects of the residents' right to refuse treatment, the care plan building on resident strengths, and other points that show how care planning supports residents' rights.
2. Care plan meetings are good forums for
  - discussing issues that involve more than one department,
  - advocating to have the resident's routines and preferences respected, and
  - accommodating resident participation and decision-making to individualize care.
3.  Distribute the National Citizens' Coalition for Nursing Home Reform's (NCCNHR) consumer information sheet, *Assessment and Care Planning: The Key to Good Care*.
  - Highlight sections on page 2 listing how to prepare and tips on making the meeting work for the resident.
  - Encourage trainees to read the entire handout.
  - Encourage trainees to use this information in talking with residents or families or to give to consumers.
  - Offer tips on how to work care planning into

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conversations.

4.  Use the handout, *Cases and Care Plan Examples*, to discuss differences in the traditional approach to writing care plans and an individualized approach.
  - Discuss how the differences in the care plans might influence a caregiver's attitude.
  - Which type of care plan is more supportive of residents' rights? Why? How?
  - If a facility refuses to write care plans in the resident's voice, how can a care plan capture individualized approaches and focus on "needs" instead of "problems"?

**B. Care planning can support residents' rights.**

1.  For an example of how care planning can support residents' rights, routines and preferences, look at the video, *Nursing Home Care Plans: Getting Good Care*, 16 minutes.
  - "How did the care planning on the video support individual preferences?" Briefly discuss.
  - "How did the care planning on the video support residents' rights?"  
"What did facility personnel say about individualizing care planning and involving residents and family members?"
2. Prepare trainees to expect that care planning in the facilities they visit may not be as "resident focused" and "consumer friendly" as the examples on the video.
  - Give a few tips on what to do if problems with care plans arise. Avoid extending this into another content block due to time constraints and the danger of information overload for new LTCO.

**➤ Key points:**

- The law and regulations provide for a care-planning process.
- Care planning is an ideal time for residents to exercise their rights to participate in planning care,

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- in making choices about life and care, in exercising control over daily routines, and in talking with staff.
- Care planning is a good time to deal with many issues.
  - LTCO need to encourage residents and families to take an active role in care-planning conferences.
  - LTCO have resources (handouts, video) to offer consumers and facilities on making care planning work for everyone.

**YOUR NOTES****IV. Focus on Selected Residents' Rights**

(One hour unless you can extend the length of this training segment.)

The purpose is to alert LTCO to a few of the typical issues they need to understand. Avoid trying to teach every right in detail or trainees will be overwhelmed and retain little. **You want trainees to know how to think about identifying and approaching residents' rights issues.** Additional information can be taught through a continuing education training session, supervision, or by providing guidance on specific cases.

- A. ► Focus on the rights discussed in the resource materials. Highlight the rights that LTCO will frequently encounter or on the rights that generate the highest number of complaints in your state. Use classroom time on the most important areas for new LTCO and for application of the rights information in LTCO work.
1. ► Use short case examples to illustrate typical situations. (You supply the case examples.)
  2. Read and discuss the pertinent right. For rights with lots of specifics like transfer/discharge, cover the highlights such as:
    - written notice is required,
    - the notice has to include certain types of information,
    - there is an appeals process,
    - it is important to advise residents to immediately file an appeal and then begin sorting out the details and alternatives.

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3. Discuss what an appropriate practice would be and how providers are supporting and encouraging residents in exercising this right.
4. ► Use handouts pertinent to the right being discussed such as a discharge notice and ask trainees to analyze the notice to see if it meets the criteria stated in the requirements. (You supply the handouts to accompany the rights you select and to be state specific.)
5. Give brief tips for how new LTCO can:
  - help educate and inform residents about this right and
  - respond if they encounter problems in this area.

**B.** Use additional, **optional activities** for reinforcing the content or for introducing resources. Some examples follow.

1. Ask experienced LTCO to share tips related to the rights that were discussed.
2. Apply residents' rights to the experience of trainees. Ask for any observations based on personal experiences.
3. Play the Residents' Rights Bingo game and discuss various ways to use it with different audiences. For information about obtaining a copy, contact The Legal Center, 455 Sherman Street, Denver, Colorado 80203, (800)288-1376.
4. Refer to the Residents' Rights packets developed by NCCNHR for additional ideas and activities, [www.nursinghomeaction.org](http://www.nursinghomeaction.org)

**V. Other Resources** ( Fifteen to thirty minutes)

During an initial training, it is usually information overload to cover the following topics in detail. Trainees might become overwhelmed and will not retain the information. The purpose of including the following topics in this chapter is to introduce the concepts and to be sure trainees know who to turn to for assistance in any of

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these areas. Additional training on these topics will be necessary and is typically better understood and retained by individuals who have been serving as LTCO for awhile.

These topics can be handled in a conversational manner by asking trainees about their personal experiences or information gained with any of these prior to attending training.

### A. Residents' Councils

1. Explain Residents' Councils.
  - Purpose
  - Law and requirements, federal and state
  - Examples of what can be accomplished
2. Explain the role of a new LTCO with residents' councils.
  - Meeting the officers
  - When to attend a meeting
  - LTCO role in a council meeting
  - How to support the council
  - When to make referrals to the council
3. Resources are available
  - Who to contact for more information
  - When additional training and information might be obtained

### B. Family Councils

1. Introduce this topic in a similar manner to the residents' council topic.
2. Point out the key differences in the two councils and discuss why each is needed.

### C. Decision-Making Tools

1. ► Provide an overview of the various decision-making tools available in California.
2. Provide basic tips for LTCO when a resident's decision-making ability is questionable. Defer more discussion about this topic until the chapter on problem solving.

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- To add continuity and check for understanding, ask how Mary would have proceeded if Mrs. Woods' memory seemed unreliable when they were talking.
  - Would Mary have followed up on any of the coffee issues?
  - Why or why not?
  - How?
- 3. Provide basic tips for LTCO when a resident has a conservator. Defer more discussion about this topic until the chapter on problem solving.
  - Ask how Mary would have proceeded if Mrs. Woods' had a conservator.
    - Would Mary have followed up on any of the coffee issues?
    - Why or why not?
    - How?
- 4. Discuss what to do if new LTCO have questions about a resident's decision-making ability when they are working with cases (until they have more knowledge and experience in this area.)
- 5. Discuss resources for information, when and how to access these.
- 6. Optional activity: Use the scripted role play, *Guardians*, to illustrate some of the key points. If you use this role play, allow additional time for this content segment.

**YOUR NOTES**

# **APPENDIX A**

## **Handouts for Exercises**



**CASE INTAKE SUMMARY<sup>1</sup>**

Case No: 7/01/STAR 9 Referred from State Computer No. \_\_\_\_\_

Facility: Starbuck NH Ombudsman: Mary Keller

Date received: 7/13/04	Work initiated: 7/13/04
Contact Type: <input type="checkbox"/> Phone <input type="checkbox"/> Mail <input type="checkbox"/> Office <input checked="" type="checkbox"/> Home Visit	
Complainant Type: <input checked="" type="checkbox"/> Resident <input type="checkbox"/> Relative/ friend <input type="checkbox"/> Ombudsman <input type="checkbox"/> Facility Administrator or staff <input type="checkbox"/> Anonymous <input type="checkbox"/> Non relative legal guardian <input type="checkbox"/> Physician/other medical staff <input type="checkbox"/> Rep. of other health/soc svc. program <input type="checkbox"/> Other _____	
Relation to Res: <input checked="" type="checkbox"/> Self <input type="checkbox"/> No Relation <input type="checkbox"/> Unknown <input type="checkbox"/> Relative _____	
<input type="checkbox"/> Permission to tell resident of contact <input type="checkbox"/> Anonymous <input checked="" type="checkbox"/> New (Check if this is the first complaint made by this complainant since October 1).	
Problem: <u>1. Coffee cold, unavailable; 2. RM=s TV too loud; 3. too few visitors from community</u>	
Coding Summary: Complaint Category _____ Complaint Number _____ Complaint __of __:	
<b>Investigation:</b> <input type="checkbox"/> Verified <input type="checkbox"/> Not Verified <b>OLAP Attorney:</b> Contacted : Y / N	
<b>Disposition:</b> <input type="checkbox"/> Resolved <input type="checkbox"/> Partially Resolved <input type="checkbox"/> Not Resolved <input type="checkbox"/> Withdrawn <input type="checkbox"/> No Action Needed <input type="checkbox"/> Referred, final disposition not obtained <input type="checkbox"/> Referred, other agency failed to act <input type="checkbox"/> Gov't policy or regulatory change needed	
<b>Agency Ref:</b> <input type="checkbox"/> Health Dept. <input type="checkbox"/> AG=s Office <input type="checkbox"/> Law Enforcement <input type="checkbox"/> Adult Protective Services <input type="checkbox"/> Advocacy Center <input type="checkbox"/> Other _____ <b>Date Ref:</b> _____	
<b>Consent:</b> <input type="checkbox"/> Written <input type="checkbox"/> Verbal <input type="checkbox"/> Unable <b>Consent Date:</b> _____	
<b>Date Closed:</b> _____	

Rev 1/02

<sup>1</sup> Developed by Linda Sadden, Louisiana State Long-Term Care Ombudsman, to go with the Basic Complaint Handling video.

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**Mrs. Woods: ANALYSIS OF LAW AND REGULATION**

What laws, regulations, and/or standards might apply to Mrs. Woods' coffee issues?

**OBRA 87 (federal Nursing Home Reform law):**

- (c) *Requirements relating to residents' rights*
  - (1) *General rights*
  - (A) *Specified rights*
  - (v) *Accommodation of needs*
  - (I) *to reside and receive services with reasonable accommodation of individual needs and preferences, except where the health or safety of the individual or other residents would be endangered.*
  
- (vi) *Grievances. Right to voice grievances ...w/out discrimination or reprisal ... and the right to prompt efforts to resolve.*

**Medicaid/Medicare Requirements (federal requirements):**

483.15. *Quality of life.*

- (e) *Accommodation of needs*
- (1) *Reside and receive services w/ reasonable accommodation of individual needs and preferences except when the health or safety of the individual or other residents would be endangered.*

483.35. *Dietary services.*

- (d) *food*
- (2) *food that is palatable, attractive, and at the proper temperature.*

483.10 *Resident rights*

- (f) *Grievances*
- (1) *voice grievances*
- (2) *prompt efforts to resolve*

**California Code of Regulations, Title 22, Chapter 3, Article 5 (skilled nursing facilities)**

72527 *Patients' Rights*

- (7) *To voice grievances and recommend changes...free from ...interference, discrimination or reprisal*
- (11) *To be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and in care of personal needs.*

# ASSESSMENT and CARE PLANNING: THE KEY TO GOOD CARE

## Consumer Information Sheet

Each and every person in a nursing home has a right to good care under the 1987 Federal Nursing Home Reform Law. The law, which is part of the Social Security Act, says that a nursing home must help each resident "attain or maintain" his or her highest level of well being - physically, mentally, and emotionally. To give good care, staff must **assess** and **plan care** to support each resident's life-long patterns, current interests, strengths, and needs. Care planning conferences are a valuable forum for residents and families to voice concerns, ask questions, give suggestions, learn nursing home strategies, and give staff information (such as resident background and daily routine). This requirement in the law is vital to making sure residents get good care.

### **Resident Assessment**

Assessments gather information about the health and physical condition of a resident and how well a resident can take care of themselves. This includes assessing when help may be needed in activities of daily living (ADLs) or "functional abilities" such as walking, eating, dressing, bathing, seeing, hearing, communicating, understanding, and remembering. Assessments also should examine a residents' habits, activities, and relationships in order to help him or her live more comfortably and feel at home in the facility.

The assessment helps staff to be aware of strengths of the resident and also determine the reason for difficulties a resident is having. An example of where a good assessment helps: A resident begins to have poor balance. This could be the result of medications, sitting too much, weak muscles, poorly fitting shoes, or a urinary or

ear infection. Staff must find out the cause of a problem in order to give good treatment. Figuring out the cause is much easier with a good assessment.

Assessments must be done within 14 days of the resident's admission to a nursing home (or 7 days for Medicare residents) and at least once a

year after that. Reviews are held every three months and when a resident's condition changes.

### **Plan of Care**

After the assessment is completed, the information is analyzed and a care plan is developed to address all the needs and concerns of the resident. The initial care plan must be completed within seven days after the assessment. The care plan is a strategy for how the staff will help a resident every day. This care plan says what each staff person will do and when it will happen (for example, a nursing assistant will help Mrs. Jones walk to each meal to build her strength). Care plans must be reviewed regularly to make sure they work and must be revised as needed. For care plans to work, residents must feel they meet their needs and must be comfortable with them.

### **Care Planning Conference**

The care plan is developed by an interdisciplinary team -- nurse, nurse aide, activities and dietary staff, and social worker, **with critical input from the resident and/or family members.** All participants discuss the resident's care at a Care Plan Conference to make certain that all medical and non-medical issues, including meals, activities, therapies, personal schedule,

medical and nursing care, and emotional needs are agreed upon and addressed. Resident and family member concerns should be listened to by staff and addressed in the care plan. A good Care Plan Conference takes time. It should not be rushed, and could take at least one hour. Every 90 days after development of the initial plan, or whenever there is a big change in a resident's physical or mental health, a Care Plan Conference is held to determine how things are going and if changes need to be made.

### ***Good Care Plans Should***

- Be specific to that resident;
- Be followed as an important guideline for providing good care for the resident;
- Be written so that everyone can understand it and know what to do;
- Reflect the resident's concerns and support his or her well-being;
- Use a team approach involving a wide variety of staff and outside referrals as needed;
- Assign tasks to specific staff members;
- Be re-evaluated and revised routinely.

### ***Steps for Residents and Family Participation in Care Planning***

Residents and family members have the right to be involved in the care plan conference in order to make choices about care, services, daily schedule, and life in the nursing home. Even if a resident has dementia, involve them in care planning as much as possible. Be aware that they may understand and communicate at some level and help the staff to find ways to communicate and work with them. They can express when they hurt or suffer if they are actively listened to. Participating in care plan conferences is a way to be heard, raise questions, and come to a clear agreement with the facility about how the resident will be cared for.

### ***Before the meeting:***

- Ask staff to hold the meeting at a convenient time for you and/or your family member;
- Ask for a copy of the current care plan (if one already exists) so that you can examine each aspect thoughtfully;
- Know about or ask the doctor or staff about your or your loved one's condition, care, and treatment;
- Plan your list of questions, needs, problems, and goals, and;
- Think of examples and reasons to support changes you recommend in the care plan.

### ***During the meeting:***

- Make sure the resident is involved and listened to carefully.
- Discuss options for treatment and for meeting your needs and preferences;
- Ask questions if you need terms or procedures explained to you;
- Be sure you understand and agree with the care plan and feel it meets your needs;
- Ask for a copy of the care plan;
- Find out who to talk to if changes in the care plan are needed, and;
- Find out who to talk to if there are problems with the care being provided.

### ***After the meeting:***

- Monitor whether the care plan is being followed;
- Inform the resident's doctor about the care plan if s/he was not directly involved;
- Talk with nurse aides, staff or the doctor about the care plan, and;
- Request another meeting if the plan is not being followed.
- See NCCNHR's "Resolving Problems in Nursing Homes" for additional information.

## CASES AND CARE PLAN EXAMPLES

Developed by Susan Misiorski and Lynn MacLean  
Apple Health Care Inc. Avon, Connecticut

### CASE A

Joe is an 88-year old man with dementia. He has a short attention span. He is very pleasant most of the time. Joe likes to walk around the facility a considerable amount of his waking hours. He is unable to distinguish between areas he is allowed to enter and those which he should not. His ambulation skills are excellent, no assistance is required. Some residents are disturbed by him because he may enter their rooms against their wishes. He prefers to be with staff at all times; he does not tolerate being alone. He and his wife raised 11 children. Joe owned a hardware store and was a respected businessman in town.

### TRADITIONAL CARE PLAN

#### Problem

Wanders due to dementia

#### Goal

Resident will not wander into other resident rooms through next Resident Care Conference (RCC).

#### Approaches

Re-direct resident to appropriate areas of facility. Praise for cooperation. Teach not to go into rooms with sashes across the door.

Short attention span

Resident will participate in one group program per week for 15 minutes through next RCC.

Invite to group activities. Praise for participation.

**CASE A: INDIVIDUALIZED CARE PLAN**

*Developed by Susan Misiorski and Lynn MacLean  
Apple Health Care Inc. Avon, Connecticut*

**Needs**

I need to walk and I particularly enjoy time with staff.

**Goal**

I will continue to walk freely throughout my home.

**Approaches**

I eat breakfast in the DR in my pajamas and robe. After breakfast, please assist me with AM care.

I need cueing but give me the opportunity to do as much as I can for myself. After AM care, I want to go to the rec activity or walk with staff.

I like to assist staff with writing, folding linen, and stocking shelves. Please let me help you.

I like to make rounds with staff and greet fellow residents along the way.

I prefer my noon meal in the small DR.

I do not like to nap in the afternoon.

If weather permits, please take me for a walk outside.

Please invite me to staff in-services and meetings.

At group activities, I like to sit next to the rec director.

I eat my evening meal in the small DR.

I like to keep walking in the evening. I go to bed around 11 PM.

**CASE B**

*Developed by Susan Misiorski and Lynn MacLean  
Apple Health Care Inc. Avon, Connecticut*

**CASE B**

Fred is an 84-year old man with osteoarthritis. He is very pleasant and social. He frequently visits staff and residents. He ambulates with minimal assistance or moves around the facility independently in a wheelchair. His wife was a resident in the facility, and they shared a room until she passed away 6 months ago. They were happily married for 61 years. They did not have children. Since his wife died, he is in a private room. Recently he began acting out sexually “grabbing at staff and female residents’ breasts”. He is alert and aware of his actions. He has minimal cognitive impairment and is hard of hearing.

To complicate the situation, the facility received a citation 6 months ago for “failing to protect a resident from abuse because another male resident was found touching a confused female resident in her genital area within 24 hours of his admission to the facility”. This was a Connecticut Public Health Code Citation. The staff are afraid of what the Health Department will do if this was to recur.

**TRADITIONAL CARE PLAN**

**Problem**

Inappropriate sexual behavior

**Goal**

Resident will not touch staff or residents against their wishes.

**Approaches**

Q 15-minute checks to monitor location.

Praise appropriate behavior.

Re-direct and allow time alone in room when sexual behavior occurs.

Private room.

**CASE B: INDIVIDUALIZED CARE PLAN**

*Developed by Susan Misiorski and Lynn MacLean  
Apple Health Care Inc. Avon, Connecticut*

**Needs**

I need companionship.

**Goal**

I will choose a room-mate by next RCC.

**Approaches**

I prefer to have a roommate.

When I'm in my room, I like to watch movies on my VCR. I especially like action movies. Please share any you may have with me.

I also like to read books.

I look up words I don't know in my dictionary. I like to teach these words.

I enjoy wild birds. I have a bird feeder outside my window. Please leave shades open and ensure I have bird seed so I can fill the feeder.

When I'm out of my room, I enjoy eating in the DR.

Please offer me many opportunities to be around staff and other residents. (I like games, sports and entertainment.) I may not talk a lot, but I like the company.

Speak clearly and directly to me, hearing has become difficult.

Please introduce me to single women who are also seeking companionship/friendship.

## GUARDIANS<sup>1</sup>

*Developed and Shared by the Missouri Long-Term Care Ombudsman Program*

*For clarity, in California the term conservator usually refers to adults over the age of eighteen while the term guardian usually refers to children under the age of eighteen. These terms are frequently interchanged and can be confusing because even in the Welfare and Institutions Code sections 9700 to 9745, which contain the State laws concerning the Ombudsman program, you find both terms.*

### OBJECTIVES

1. To transmit factual information to LTCO about Conservatorship issues.
2. To model interaction with residents and their family members.
3. To model interaction with staff.
4. To stimulate LTCO to think creatively about alternatives.

### CHARACTERS

Ombudsman (LTCO)

Mrs. Reddy, a resident

Social services designee or social worker

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LTCO: Hello, Mrs. Reddy, how are you today?

Mrs. Reddy: O.K.

LTCO: This facility is very quiet this afternoon. Where is everyone?

Mrs. Reddy: They all went to the mall this afternoon.

LTCO: Didn't you want to go?

Mrs. Reddy: I wanted to, but my daughter wouldn't let me.

LTCO: Why didn't your daughter want you to go?

Mrs. Reddy: Oh, she said that there was no reason for me to go because she sees that I have everything I need. She does do that but it would have been good just to get out. I've been here six months now. I've almost forgotten what the outside looks like.

LTCO: Is your daughter your conservator?

Mrs. Reddy: I guess so. She pays my bills and buys me things.

LTCO: Did you go to court?

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<sup>1</sup> Excerpted from, *Scripted Role Plays*, Helping Residents' Rights Take Root, June 1995.

Mrs. Reddy: I don't think so, at least, I don't remember any court.

LTCO: Even if your daughter is your conservator, you still have the right to make decisions about your own daily activities. You know, if you'd like to find out more about your situation, you could ask the social worker to come down and talk with you.

Mrs. Reddy: Oh, I'd like to find out, but I don't want to cause any trouble. Will you ask her to meet with me? Will you stay for the meeting, too?

LTCO: With your permission, I would be happy to stay with you and listen to the discussion with the social worker. You aren't causing any trouble. You need that information and I can tell it is important to you.

## **SCENE 2**

Ombudsman returns to resident's room with social worker.

LTCO: Mrs. Reddy and I were just talking about how she would have liked to have gone to the mall today but was told she couldn't go.

Mrs. Reddy: Yes, I really wanted to go, just to get out.

Social Worker: Well, your daughter just doesn't think it is necessary for you to go out, as she does all your shopping for you.

LTCO: I think Mrs. Reddy would enjoy the trip beyond the need to do her shopping. Why don't you share what you told me just a few minutes ago?

Mrs. Reddy: I just said I haven't been out of this place for six weeks and have almost forgotten what the outside looks like. I know my daughter gets me things I need, but I need to start doing for myself and getting out would be something I would really enjoy.

LTCO: One thing I thought we needed to clear up is whether or not Mrs. Reddy's daughter is her conservator.

Social Worker: No, Mrs. Reddy's daughter is just her responsible party and I believe she does have her power of attorney to handle her finances and an Advance Health Care Directive, but no Conservatorship.

LTCO: Well in that case, Mrs. Reddy does have the right to make her own decisions like when she can go out. Can I enlist your help in ensuring that in the future she is allowed to do so?

## **DISCUSSION**

1. Assume the social worker isn't so agreeable with the LTCO's request. What further statements can you make to see that Mrs. Reddy is allowed to make decisions for herself?
2. How would you respond to the social worker claiming the family will really be upset if they don't listen to the daughter?
3. What would be your response if the social worker said the daughter had full Conservatorship for her mother?

## **APPENDIX B**

### **Handout Excerpts from Federal and State Regulatory Provisions**

State Operations Manual  
Appendix PP - Guidance to Surveyors for Long Term Care  
Facilities

**Excerpts on: Quality of Care, Care Plans**

(Rev. 5, 11-19-04)

<http://www.cms.hhs.gov/manuals>

**F309**

(Rev. 4, Issued 11-12-04, Effective: 11-12-04, Implementation: 11-12-2004)

**§483.25 Quality of Care**

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

Use F309 for quality of care deficiencies not covered by §483.25(a)-(m).

**Intent: §483.25**

The facility must ensure that the resident obtains optimal improvement or does not deteriorate within the limits of a resident's right to refuse treatment, and within the limits of recognized pathology and the normal aging process.

**Definitions: §483.25**

- "Highest practicable" is defined as the highest level of functioning and well-being possible, limited only by the individual's presenting functional status and potential for improvement or reduced rate of functional decline. Highest practicable is determined through the comprehensive resident assessment by competently and thoroughly addressing the physical, mental or psychosocial needs of the individual.

**Guidance to Surveyors §483.25**

Use F309 when the survey team determines there are quality of care deficiencies not covered by §§483.25(a)-(m). "Highest practicable" is defined as the highest level of functioning and well-being possible, limited only by the individual's presenting functional status and potential for improvement or reduced rate of functional decline. Highest practicable is determined through the comprehensive resident assessment by competently and thoroughly addressing the physical, mental or psychosocial needs of the individual.

The facility must ensure that the resident obtains optimal improvement or does not deteriorate within the limits of a resident's right to refuse treatment, and within the limits of recognized pathology and the normal aging process.

In any instance in which there has been a lack of improvement or a decline, the survey team must determine if the occurrence was unavoidable or avoidable. A determination of unavoidable decline or failure to reach highest practicable well-being may be made only if all of the following are present:

- An accurate and complete assessment (see §483.20 );
- A care plan which is implemented consistently and based on information from the assessment;
- Evaluation of the results of the interventions and revising the interventions as necessary.

Determine if the facility is providing the necessary care and services based on the findings of the RAI. If services and care are being provided, determine if the facility is evaluating the outcome to the resident and changing the interventions if needed. This should be done in accordance with the resident's customary daily routine. Use Tag F309 to cite quality of care deficiencies that are not explicit in the quality of care regulations.

### **Procedures §483.25**

Assess a facility's compliance with these requirements by determining if the services noted in the plan of care, based on a comprehensive and accurate functional assessment of the resident's strengths, weaknesses, risk factors for deterioration and potential for improvement, is continually and aggressively implemented and updated by the facility staff. In looking at assessments, use the MDS and RAPs information, any other pertinent assessments, and resulting care plans.

If the resident has been in the facility for less than 14 days (before completion of all the RAI is required), determine if the facility is conducting ongoing assessment and care planning, and, if appropriate, care and services are being provided.

If quality of care problems are noted in areas of nurse aide responsibility, review nurse aide competency requirements at §483.75(e) .

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**F279**

**(Rev. 5, Issued: 11-19-04, Effective: 11-19-04, Implementation: 11-19-04)**

**§483.20(d) (A facility must..) use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.**

**§483.20(k) Comprehensive Care Plans**

**(1) The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following:**

**(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and**

**(ii) Any services that would otherwise be required under [§483.25](#) but are not provided due to the resident's exercise of rights under [§483.10](#), including the right to refuse treatment under [§483.10\(b\)\(4\)](#).**

**Interpretive Guidelines §483.20(k):**

An interdisciplinary team, in conjunction with the resident, resident's family, surrogate, or representative, as appropriate, should develop quantifiable objectives for the highest level of functioning the resident may be expected to attain, based on the comprehensive assessment. The interdisciplinary team should show evidence in the RAP summary or clinical record of the following:

- The resident's status in triggered RAP areas;
- The facility's rationale for deciding whether to proceed with care planning; and
- Evidence that the facility considered the development of care planning interventions for all RAPs triggered by the MDS.

The care plan must reflect intermediate steps for each outcome objective if identification of those steps will enhance the resident's ability to meet his/her objectives. Facility staff will use these objectives to monitor resident progress. Facilities may, for some residents, need to prioritize their care plan interventions. This should be noted in the clinical record or on the plan of care.

The requirements reflect the facility's responsibilities to provide necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. However, in some cases, a resident may wish to refuse certain services or treatments that professional staff believe may be indicated to assist the resident in reaching his or her highest practicable level of well-being. Desires of the resident should be documented in the clinical record (see guidelines at §483.10(b)(4) for additional guidance concerning refusal of treatment).

**Probes §483.20(k)(1):**

Does the care plan address the needs, strengths and preferences identified in the comprehensive resident assessment?

Is the care plan oriented toward preventing avoidable declines in functioning or functional levels?

How does the care plan attempt to manage risk factors?

Does the care plan build on resident strengths?

Does the care plan reflect standards of current professional practice?

Do treatment objectives have measurable outcomes?

Corroborate information regarding the resident's goals and wishes for treatment in the plan of care by interviewing residents, especially those identified as refusing treatment.

Determine whether the facility has provided adequate information to the resident so that the resident was able to make an informed choice regarding treatment.

If the resident has refused treatment, does the care plan reflect the facility's efforts to find alternative means to address the problem?

For implementation of care plan, see §483.20(k)(3).

State Operations Manual  
Appendix PP - Guidance to Surveyors for Long Term Care  
Facilities

**Excerpts on: Quality of Life, Selected Residents' Rights,  
Dietary**

**(Rev. 5, 11-19-04)**

<http://www.cms.hhs.gov/manuals>

**F240**

**§483.15 Quality of Life**

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

**Interpretive Guidelines §483.15**

The intention of the quality of life requirements is to specify the facility's responsibilities toward creating and sustaining an environment that humanizes and individualizes each resident. Compliance decisions here are driven by the quality of life each resident experiences.

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**F241**

**§483.15(a) Dignity**

**The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.**

**Interpretive Guidelines §483.15(a)**

"Dignity" means that in their interactions with residents, staff carries out activities that assist the resident to maintain and enhance his/her self-esteem and self-worth. For example:

- Grooming residents as they wish to be groomed (e.g., hair combed and styled, beards shaved/trimmed, nails clean and clipped);
- Assisting residents to dress in their own clothes appropriate to the time of day and individual preferences;
- Assisting residents to attend activities of their own choosing;
- Labeling each resident's clothing in a way that respects his or her dignity;

- Promoting resident independence and dignity in dining (such as avoidance of day-to-day use of plastic cutlery and paper/plastic dishware, bibs instead of napkins, dining room conducive to pleasant dining, aides not yelling);
- Respecting resident's private space and property (e.g., not changing radio or television station without resident's permission, knocking on doors and requesting permission to enter, closing doors as requested by the resident, not moving or inspecting resident's personal possessions without permission);
- Respecting resident's social status, speaking respectfully, listening carefully, treating residents with respect (e.g., addressing the resident with a name of the resident's choice, not excluding residents from conversations or discussing residents in community setting); and
- Focusing on residents as individuals when they talk to them and addressing residents as individuals when providing care and services.

**Procedures §483.15(a)**

For sampled residents, use the Resident Assessment Instrument (RAI) and comprehensive care plan to consider the resident's former life style and personal choices made while in the facility to obtain a picture of characteristic resident behaviors. As part of the team's information gathering and decision-making, look at the actions and omissions of staff and the uniqueness of the individual sampled resident and on the needs and preferences of the resident, not on the actions and omissions themselves.

Throughout the survey, observe: Do staff show respect for residents? When staff interact with a resident, do staff pay attention to the resident as an individual? Do staff respond in a timely manner to the resident's requests for assistance? In group activities, do staff focus attention on the group of residents? Or, do staff appear distracted when they interact with residents? For example, do staff continue to talk with each other while doing a "task" for a resident(s) as if she/he were not present?

If the survey team identifies potential compliance issues regarding the privacy of residents during treatment, refer to §483.10(e), F164 .

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**F242**

**§483.15(b) Self-Determination and Participation**

The resident has the right to--

(1) Choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care;

(2) Interact with members of the community both inside and outside the facility; and

(3) Make choices about aspects of his or her life in the facility that are significant to the resident.

**Procedures §483.15(b)**

Observe how well staff know each resident and what aspects of life are important to him/her. Determine if staff make adjustments to allow residents to exercise choice and self-determination.

Review MDS Background Information III (MDS version 2.0 section AC) for customary routines. For sampled residents, review MDS to determine level of participation in assessment and care planning by resident and family members. Review MDS, section G (MDS version 2.0 section F) for Psychosocial Well-Being and Care Planning.

If the facility has failed to reasonably accommodate the preferences of the resident consistent with interests, assessments and plan of care, see §483.15(e), F246 .

**Interpretive Guidelines §483.15(b)(3)**

The intent of this requirement is to specify that the facility must create an environment that is respectful of the right of each resident to exercise his or her autonomy regarding what the resident considers to be important facets of his or her life. For example, if 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. (See §483.10(b)(1) ). Or, if a resident mentions that her therapy is scheduled at the time of her favorite television program, the facility should accommodate the resident to the extent that it can.

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**F243**

**§483.15(c) Participation in Resident and Family Groups**

- (1) A resident has the right to organize and participate in resident groups in the facility;**
- (2) A resident's family has the right to meet in the facility with the families of other residents in the facility;**
- (3) The facility must provide a resident or family group, if one exists, with private space;**
- (4) Staff or visitors may attend meetings at the group's invitation;**
- (5) The facility must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings;**

**SEE INTERPRETIVE GUIDANCE FOR §483.15(c) AT TAG F244**

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**F244**

**§483.15(c)(6) When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.**

**Interpretive Guidelines §483.15(c)**

This requirement does not require that residents' organize a residents or family group. However, whenever residents or their families wish to organize, facilities must allow them to do so without interference. The facility must provide the group with space, privacy for meetings, and staff support. Normally, the designated staff person responsible for assistance and liaison between the group and the facility's administration and any other staff members attend the meeting only if requested.

- "A resident's or family group" is defined as a group that meets regularly to:
  - o Discuss and offer suggestions about facility policies and procedures affecting residents' care, treatment, and quality of life;
  - o Support each other;
  - o Plan resident and family activities;

- o Participate in educational activities; or
- o For any other purpose.

The facility is required to listen to resident and family group recommendations and grievances. Acting upon these issues does not mean that the facility must accede to all group recommendations, but the facility must seriously consider the group's recommendations and must attempt to accommodate those recommendations, to the extent practicable, in developing and changing facility policies affecting resident care and life in the facility. The facility should communicate its decisions to the resident and/or family group.

**Procedures §483.15(c)** If no organized group exists, determine if residents have attempted to form one and have been unsuccessful, and, if so, why.

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## **F245**

### **§483.15(d) Participation in Other Activities**

**A resident has the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility. Interpretive**

**Guidelines §483.15(d)** The facility, to the extent possible, should accommodate an individual's needs and choices for how he/she spends time, both inside and outside the facility. Ask the social worker or other appropriate staff how they help residents pursue activities outside the facility.

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**F246 (Rev. 5, Issued 11-19-04, Effective: 11-19-04, Implementation: 11-19-2004)**

### **§483.15(e) Accommodation of Needs**

**A resident has a right to --**

**§483.15(e)(1) Reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered; and**

**ALSO SEE INTERPRETIVE GUIDANCE AT TAG F247**

### **§483.70(c) Space and equipment**

**The facility must--**

**(1) Provide sufficient space and equipment in dining, health services, recreation, and program areas to enable staff to provide residents with needed services as required by these standards and as identified in each resident's plan of care; and**

**Intent §483.70 (c)(1)**

The intent of this regulation is to ensure that dining, health services, recreation, activities and programs areas are large enough to comfortably accommodate the needs of the residents who usually occupy this space. Dining, health services, recreation, and program areas should be large enough to comfortably accommodate the persons who usually occupy that space, including the wheelchairs, walkers, and other ambulating aids used by the many residents who require more than standard movement spaces. "Sufficient space" means the resident can access the area, it is not functionally off-limits, and the resident's functioning is not restricted once access to the space is gained.

Program areas where resident groups engage in activities focused on manipulative skills and hand-eye coordination should have sufficient space for storage of their supplies and "works in progress."

Program areas where residents receive physical therapy should have sufficient space and equipment to meet the needs of the resident's therapy requirement.

Recreation/activities area means any area where residents can participate in those activities identified in their plan of care.

**Procedures §483.70(c)(1)**

In the use of space, consider if available space allows residents to pursue activities and receive health services and programs as identified in their care plan.

**§483.70(2) The facility must provide each resident with--**

- (i) A separate bed of proper size and height for the convenience of the resident;**
- (ii) A clean, comfortable mattress;**
- (iii) Bedding appropriate to the weather and climate; and**

**Probes: §483.70(d)(2)(i), (ii), and (iii)**

Are mattresses clean and comfortable?

Is bedding appropriate to weather and climate?

**§483.70(d)(2)(iv) Functional furniture appropriate to the resident's needs, and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident.**

**Interpretive Guidelines §483.70(d)(2)(iv)**

"Functional furniture appropriate to the residents' needs" means that the furniture in each resident's room contributes to the resident attaining or maintaining his or her highest practicable level of independence and well-being. In general, furnishings include a place to put clothing away in an organized manner that will let it remain clean, free of wrinkles, and accessible to the resident while protecting it from casual access by others; a place to put personal effects such as pictures and a bedside clock, and furniture suitable for the comfort of the resident and visitors (e.g., a chair).

There may be instances in which individual residents determine that certain items are not necessary or will impede their ability to maintain or attain their highest practicable well-being (e.g., Both the resident and spouse use wheelchairs. They visit more easily without another chair in the room.) In this case, the resident's wishes should determine the furniture needs.

"Shelves accessible to the resident" means that the resident, if able, or a staff person at the direction of the resident, can get to their clothes whenever they choose.

**Probes: §483.70(d)(2)(iv)**

Functional furniture: Is there functional furniture, appropriate to residents' needs?

Closet space: Is there individual closet space with accessible clothes racks and shelves?

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**F247**

**A resident has a right to—**

**§483.15(e)(2) Receive notice before the resident's room or roommate in the facility is changed.**

**Interpretive Guidelines §483.15(e)**

"Reasonable accommodations of individual needs and preferences," is defined as the facility's efforts to individualize the resident's environment. The facility's physical environment and staff behaviors should be directed toward assisting the resident in maintaining and/or achieving independent functioning, dignity, and well-being to the extent possible in accordance with the resident's own preferences, assessment and care plans. The facility should attempt to adapt such things as schedules, call systems,

and room arrangements to accommodate residents' preferences, desires, and unique needs.

This requirement applies to areas and environment in accordance with needs and preferences NOT addresses at: §§483.10(k), Telephone; 483.10(1), Personal Property; 483.10(m) , Married Couples; 483.15(b), Self-Determination and Participation; 483.15(f)(1) , Activities; 483.15(g)(1) , Social Services; 483.15(h)(1), Homelike Environment; 483.25(a)(2) and (3), Activities of Daily Living; 483.25(f)(1), Psychosocial functioning; 483.25(h)(2), Accidents, Prevention-Assistive devices; 483.35(d)(3), Food prepared in a form designed to meet individual needs.

The facility must demonstrate that it accommodates residents' needs. For example, if the resident refuses a bath because he or she prefers a shower, prefers it at a different time of day or on a different day, does not feel well that day, is uneasy about the aide assigned to help or is worried about falling, the staff should make the necessary adjustments realizing the resident is not refusing to be clean but refusing the bath under the circumstance provided. The facility staff should meet with the resident to make adjustments in the care plan to accommodate his or her needs.

This includes learning the residents' preferences and taking them into account when discussing changes of rooms or roommates and the timing of such changes. In addition, this also includes making necessary adjustments to ensure that residents are able to reach call cords, buttons or other communication mechanisms, as well as accommodating food activities or room choices.

**Procedures §483.15(e)**

Observe resident-staff interaction and determine to what extent staff attempt to accommodate residents' preferences. For those areas not addressed in other regulations, determine what happens when a resident states a preference in the form of a refusal. How does the staff attempt to learn what the resident is refusing, and why, and make adjustments to an extent practicable to meet the resident's needs?

**Probes: §483.15(e)**

- Are rooms arranged such that residents in wheel chairs can easily access personal items and transfer in and out of bed?
- Does the facility respond to residents' stated needs and preferences?
- If the resident is unable to express needs and preferences that would individualize care, has the family expressed the resident's routine and has the facility responded?

**Interpretive Guidelines §483.15(e)(1)**

Review the extent to which the facility adapts the physical environment to enable residents to maintain unassisted functioning. These adaptations include, but are not limited to:

1. Furniture and adaptive equipment that enable residents to:
  - a. Stand independently;
  - b. Transfer without assistance (e.g., arm supports, correct chair height, firm support);
  - c. Maintain body symmetry; and
  - d. Participate in resident-preferred activities.
  
2. Measures that:
  - a. Enable residents with dementia to walk freely;
  - b. Reorient and re-motivate residents with restorative potential (e.g., displaying easily readable calendars and clocks, wall hangings evocative of the lives of residents);
  - c. Promote conversation and socialization (pictures and decorations that speak to the resident's age cohort); and
  - d. Promote mobility and independence for disabled residents in going to the bathroom (e.g., grab bars, elevated toilet seats).

Determine if staff use appropriate measures to facilitate communication with residents who have difficulty communicating. For example, if necessary, does staff get at eye level, allow them to remove a resident from noisy surroundings?

Determine if staff communicate effectively with residents with cognitive impairments, such as referring in a non-contradictory way to what residents are saying, and addressing what residents are trying to express to the agenda behind their behavior.

**Probes: §483.15(e)(1)(2)**

How have residents' needs been accommodated? Do environmental adaptations enhance residents' independence, self-control, and highest practicable well-being? Is the fit between residents' needs and environment positive?

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**§483.15(f) Activities**

**§483.15(f)(1) The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.**

**Interpretive Guidelines §483.15(f)(1)**

Because the activities program should occur within the context of each resident's comprehensive assessment and care plan, it should be multi-faceted and reflect each individual resident's needs. Therefore, the activities program should provide stimulation or solace; promote physical, cognitive and/or emotional health; enhance, to the extent practicable, each resident's physical and mental status; and promote each resident's self-respect by providing, for example, activities that support self-expression and choice.

Activities can occur at anytime and are not limited to formal activities being provided by activity staff. Others involved may be any facility staff, volunteers and visitors.

**Probes: §483.15(f)(1)**

Observe individual, group and bedside activities.

1. Are residents who are confined or choose to remain in their rooms provided with in room activities in keeping with life-long interests (e.g., music, reading, visits with individuals who share their interests or reasonable attempts to connect the resident with such individuals) and in-room projects they can work on independently? Do any facility staff members assist the resident with activities he or she can pursue independently?
2. If residents sit for long periods of time with no apparently meaningful activities, is the cause:
  - a. Resident choice;
  - b. Failure of any staff or volunteers either to inform residents when activities are occurring or to encourage resident involvement in activities;
  - c. Lack of assistance with ambulation;
  - d. Lack of sufficient supplies and/or staff to facilitate attendance and participation in the activity programs.
  - e. Program design that fails to reflect the interests or ability levels of residents, such as activities that are too complex?

For residents selected for a comprehensive review, or a focused review, as appropriate, determine to what extent the activities reflect the individual resident's assessment. (See especially MDS version 2.0 sections AC, B, C, D, and N.)

Review the activity calendar for the month prior to the survey to determine if the formal activity program:

- Reflects the schedules, choices and rights of the residents;
- Offers activities at hours convenient to the residents (e.g., morning, afternoon, some evenings and weekends);
- Reflects the cultural and religious interests of the resident population; and
- Would appeal to both men and women and all age groups living in the facility.

Review clinical records and activity attendance records of residents receiving a comprehensive review, or a focused review, as appropriate, to determine if:

- Activities reflect individual resident history indicated by the comprehensive assessment;
- Care plans address activities that are appropriate for each resident based on the comprehensive assessment;
- Activities occur as planned; and

Outcomes/responses to activities interventions are identified in the progress notes of each resident.

## **F252**

**(Rev. 5, Issued: 11-19-04, Effective: 11-19-04, Implementation: 11-19-04)**

### **§483.10(I) Personal Property**

**The 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.**

### **Intent §483.10(I)**

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 §483.10(I)**

All residents' possessions, regardless of their apparent value to others, must be treated with respect, for what they are and for 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 grounds of space and health or safety.

**Procedures §483.10(I)**

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

- Residents are encouraged to have and to use them;
- The facility informs residents not to bring in certain items and for what reason;
- 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.

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**F360 §483.35 Dietary Services** 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.

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**F361**

**§483.35(a) Staffing** The facility must employ a qualified dietitian either full-time, part-time, or on a consultant basis. **§483.35(a)(1)** If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food service who receives frequently scheduled consultation from a qualified dietitian.

**§483.35(a)(2)** A qualified dietitian is one who is qualified based upon either registration by the Commission on Dietetic Registration of the American Dietetic Association, or on the basis of education, training, or experience in identification of dietary needs, planning, and implementation of dietary programs.

**Intent §483.35(a)**

The intent of this regulation is to ensure that a qualified dietitian is utilized in planning, managing and implementing dietary service activities in order to assure that the residents receive adequate nutrition.

A director of food services has no required minimum qualifications, but must be able to function collaboratively with a qualified dietitian in meeting the nutritional needs of the residents.

**Interpretive Guidelines §483.35(a)**

A dietitian qualified on the basis of education, training, or experience in identification of dietary needs, planning and implementation of dietary programs has experience or training which includes:

- Assessing special nutritional needs of geriatric and physically impaired persons;
- Developing therapeutic diets;
- Developing “regular diets” to meet the specialized needs of geriatric and physically impaired persons;
- Developing and implementing continuing education programs for dietary services and nursing personnel;
- Participating in interdisciplinary care planning;
- Budgeting and purchasing food and supplies; and
- Supervising institutional food preparation, service and storage.

**Procedures §483.35(a)**

If resident reviews determine that residents have nutritional problems, determine if these nutritional problems relate to inadequate or inappropriate diet nutrition/assessment and monitoring. Determine if these are related to dietitian qualifications.

**Probes: §483.35(a)**

If the survey team finds problems in resident nutritional status:

- Do practices of the dietitian or food services director contribute to the identified problems in residents’ nutritional status? If yes, what are they?
- What are the educational, training, and experience qualifications of the facility’s dietitian?

**F362 §483.35 (b) Standard Sufficient Staff**

The facility must employ sufficient support personnel competent to carry out the functions of the dietary service

**Interpretive Guidelines §483.35(b)**

**“Sufficient support personnel”** is defined as enough staff to prepare and serve palatable, attractive, nutritionally adequate meals at proper temperatures and appropriate times and support proper sanitary techniques being utilized.

**Procedures §483.35(b)**

For residents who have been triggered for a dining review, do they report that meals are palatable, attractive, served at the proper temperatures and at appropriate times?

**Probes: §483.35(b)**

Sufficient staff preparation:

- Is food prepared in scheduled timeframes in accordance with established professional practices?

Observe food service:

- Does food leave kitchen in scheduled timeframes? Is food served to residents in scheduled timeframes?

**F364 §483.35(d) Food**

**Each resident receives and the facility provides:**

**(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;**

**(2) Food that is palatable, attractive, and at the proper temperature;**

**Intent §483.35(d)(1)(2)**

The intent of this regulation is to assure that the nutritive value of food is not compromised and destroyed because of prolonged food storage, light, and air exposure; prolonged cooking of foods in a large volume of water and prolong holding on steam table, and the addition of baking soda. Food should be palatable, attractive, and at the proper temperature as determined by the type of food to ensure resident's satisfaction. Refer to §483.15(e) and/or §483.15(a).

**Interpretive Guidelines §483.35(d)(1)**

**“Food-palatability”** refers to the taste and/or flavor of the food. **“Food attractiveness”** refers to the appearance of the food when **served** to residents.

**Procedures §483.35(d)(1)**

Evidence for palatability and attractiveness of food, from day to day and meal to meal, may be strengthened through sources such as: additional observation, resident and staff interviews, and review of resident council minutes. Review nutritional adequacy in §483.25(i)(I).

**Probes: §483.35(d)(1)(2)**

Does food have a distinctly appetizing aroma and appearance, which is varied in color and texture? Is food generally well seasoned (use of spices, herbs, etc.) and acceptable to residents?

Conserves nutritive value:

- Is food prepared in a way to preserve vitamins? Method of storage and preparation should cause minimum loss of nutrients.

Food temperature:

- Is food served at preferable temperature (hot foods are served hot and cold foods are served cold) as discerned by the resident and customary practice? Not to be confused with the proper holding temperature.

**22 CA ADC § 72527**

22 CCR s 72527

Cal. Admin. Code tit. 22, s 72527

***EXCERPT from***

BARCLAYS OFFICIAL **CALIFORNIA CODE OF REGULATIONS**  
TITLE 22. SOCIAL SECURITY  
DIVISION 5. LICENSING AND CERTIFICATION OF HEALTH FACILITIES, HOME  
HEALTH  
AGENCIES, CLINICS, AND REFERRAL AGENCIES  
**CHAPTER 3. SKILLED NURSING FACILITIES**  
ARTICLE 5. ADMINISTRATION

This database is current through 01/12/07, Register 2007, No. 2.  
**s 72527. Patients' Rights.**

(a) Patients have the rights enumerated in this section and the facility shall ensure that these rights are not violated. The facility shall establish and implement written policies and procedures which include these rights and shall make a copy of these policies available to the patient and to any representative of the patient. The policies shall be accessible to the public upon request. Patients shall have the right:

(1) To be fully informed, as evidenced by the patient's written acknowledgement prior to or at the time of admission and during stay, of these rights and of all rules and regulations governing patient conduct.

(2) To be fully informed, prior to or at the time of admission and during stay, of services available in the facility and of related charges, including any charges for services not covered by the facility's basic per diem rate or not covered under Titles XVIII or XIX of the Social Security Act.

(3) To be fully informed by a physician of his or her total health status and to be afforded the opportunity to participate on an immediate and ongoing basis in the total plan of care including the identification of medical, nursing and psychosocial needs and the planning of related services.

(4) To consent to or to refuse any treatment or procedure or participation in experimental research.

(5) To receive all information that is material to an individual patient's decision concerning whether to accept or refuse any proposed treatment or procedure. The disclosure of material information for administration of psychotherapeutic

drugs or physical restraints or the prolonged use of a device that may lead to the inability to regain use of a normal bodily function shall include the disclosure of information listed in Section 72528(b).

(6) To be transferred or discharged only for medical reasons, or the patient's welfare or that of other patients or for nonpayment for his or her stay and to be given reasonable advance notice to ensure orderly transfer or discharge. Such actions shall be documented in the patient's health record.

(7) To be encouraged and assisted throughout the period of stay to exercise rights as a patient and as a citizen, and to this end to voice grievances and recommend changes in policies and services to facility staff and/or outside representatives of the patient's choice, free from restraint, interference, coercion, discrimination or reprisal.

(8) To manage personal financial affairs, or to be given at least a quarterly accounting of financial transactions made on the patient's behalf should the facility accept written delegation of this responsibility subject to the provisions of Section 72529.

(9) To be free from mental and physical abuse.

(10) To be assured confidential treatment of financial and health records and to approve or refuse their release, except as authorized by law.

(11) To be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and in care of personal needs.

(12) Not to be required to perform services for the facility that are not included for therapeutic purposes in the patient's plan of care.

(13) To associate and communicate privately with persons of the patient's choice, and to send and receive personal mail unopened.

(14) To meet with others and participate in activities of social, religious and community groups.