

**OFFICE OF
THE DISTRICT OF COLUMBIA LONG-TERM CARE
OMBUDSMAN**

LEGAL COUNSEL FOR THE ELDERLY

POLICIES AND PROCEDURES MANUAL

Part of the Senior Service Network funded by
The D.C. Office on Aging

Revised September 2012

TABLE OF CONTENTS

- 1.0**
Complaint Investigation and Resolution
- 1.1**
Complaint Process
- 1.2**
Coordination of Complaint Investigation Activities
- 2.0**
Access to Facilities, Residents and Records
- 2.1**
Denial of Access
- 3.0**
Training and Certification
- 3.1**
Training of Volunteer Resident Advocates
- 3.2**
Training of Ombudsman Program Staff
- 3.3**
Ombudsman Designation Requirements
- 3.4**
Designation Process
- 4.0**
Confidentiality of Communications and Records
- 5.0**
Code of Ethics

Attachments

- A. Complaint Acknowledgement Letter
- B. Monthly Visit Schedule Form
- C. Consent Form
- D. Complaint Intake Form
- E. Complaint Referral Form
- F. Federal Law
 - o F1 – Older Americans Act
 - o F2 – Nursing Home Reform Act
- G. DC Law
- H. Ombudsman Code of Ethics

1.0. COMPLAINT INVESTIGATION AND RESOLUTION

Federal and District of Columbia laws charge the District of Columbia Long-Term Care Ombudsman Program (DCLTCOP) with the duty to investigate and resolve complaints and concerns made by or on behalf of residents of long-term care facilities. A long-term care facility is defined as any licensed or unlicensed nursing homes (NHs), community residence facilities (CRFs), assisted living residences (ALRs), mental health community residence facilities (MHCRFs), and intermediate care facilities (ICFs). The DCLTCOP investigates any issues involving the health, safety, welfare, and rights of residents of these facilities.

The DCLTCOP staff and volunteers: visit residents in these facilities; take telephone calls from residents or potential residents and their family members or representatives; listen to their complaints and concerns; and, take action on behalf of long-term care residents to resolve their complaints or concerns. Complaints may also be received from staff of long-term care facilities, healthcare and social services workers in the community, and any other concerned citizens. Complainants are not required to identify themselves by name, and all resident records and identifying materials are kept strictly confidential as mandated by D.C. law. When the DCLTCOP receives complaints related to long term care facilities outside of the District of Columbia they are referred to the long term care ombudsman in the appropriate jurisdiction. However, the DCLTCOP may investigate complaints involving the transfer, discharge, or placement of D.C. residents in facilities outside of the District of Columbia.

Complaints concerning life-threatening situations are investigated as soon as possible, but no later than 12 hours after receipt. Complaints involving suspected abuse, neglect, or exploitation should be reported to Adult Protective Services (APS) and the Department of Health (DOH) or Department of Mental Health (DMH) no later than 24 hours after receipt, unless doing so would violate a resident's right to confidentiality. Other agencies such as the D.C. Medicaid Fraud Control Unit (MFCU) and the Metropolitan Police Department (MPD) are also notified if their involvement is appropriate. Complaints related to resident care and rights are generally investigated within three working days. Complaints related to the facility itself, such as environmental problems, are generally investigated within 5 to 10 working days, unless they pose an imminent threat to the health or safety of one or more residents. Non-facility related complaints such as problems with public or private benefits are investigated within 21 working days, unless the matter requires a more timely response. When the DCLTCOP receives a written complaint or electronic transmittal, an ombudsman staff must acknowledge the complaint in writing within 10 days. (See attachment A)

In addition to responding to complaints, ombudsmen are required to monitor their assigned long term care facilities. The Board and Care Ombudsman is required to make at least one visit a year to every licensed CRFs and ALRs. The Nursing Home

Ombudsmen are required to visit their assigned facilities at least once a month. In addition, they or assigned volunteers are required to visit each facility with over 100 residents at least every other week and each facility with fewer than 100 residents at least every six weeks, or as needed. A schedule of facilities to be visited is documented monthly by the appropriate ombudsman and provided to management. (See Attachment B)

For every complaint or concern that requires an ombudsman to take action on behalf of residents relevant information must be included in the ombudsman database (OmbudsManager). While not required, a case specific form can be used to aide with data entry, as this contains all of the data required for the Ombudsman Tracking System (OTS) and the National Ombudsman Reporting System (NORS) that are required by the United States Administration on Aging.

1.1. COMPLAINT PROCESS:

Step One: Reporting Complaints

Complaints are received by DCLTCOP staff and volunteers in writing, by telephone, and in person. Complaints may also be identified by staff or volunteers while in a facility. Complainants are asked to specify their desired outcome(s) and to indicate what, if any, steps have already been attempted to resolve the complaint. The ombudsman will, if applicable, obtain permission from the complainant to proceed with the complaint by executing the Ombudsman Program Consent Form. (See Attachment C) The plan of action for investigation of the complaint should be agreed upon between the complainant and the ombudsman, if possible. The ombudsman will also obtain consent from the complainant to use the resident's name in pursuing resolution of the complaint with facility personnel and/or outside agencies.

Step Two: Documenting Complaints

The Ombudsman Program staff or volunteer who receives the complaint must ensure the data is entered into the ombudsman database. Complaint information can first be documented on a case specific form before entered into the database. It must include the following: reference title, intake date, review date, ombudsman staff/volunteer, complainant, complainant role, facility, resident, resident information such as age, gender, race, pay status and nature of the complaint or complaints. (See Attachment D) For more information, OmbudsManager User Guide should be used.

Step Three: Referral

Referral is defined as sending or communicating a complaint (and/or confidential information related to the complaint) to persons, agencies, or organizations outside of DCLTCOP.

Any complaint that cannot be resolved by ombudsman staff at the facility level or

that requires further investigation by DOH, DMH or other outside agency, must be referred to that agency by electronic transmittal, fax or mail using the established form or format. (see Attachment E). However, the Ombudsman remains responsible for the tracking of the investigation and disposition of the complaint notwithstanding such referral.

Step Four: Investigation/Verification

The goal of investigation is to identify information to aid in resolution of the complaint and to provide information for potential issue development. Investigation involves a systematic, straightforward, and careful inquiry into the allegations of the complainant and statements of the respondent(s).

Ombudsmen should utilize the following techniques, as appropriate, in the investigation process:

- (1) Interview the complainant to obtain a clear statement and history of the problem;
- (2) make a personal onsite visit to the facility to assess the situation;
- (3) Interview other residents;
- (4) Interview staff and other witnesses;
- (5) Examine resident records; and
- (6) Determine what laws, regulations or policies might apply.

If a complaint cannot be substantiated, the ombudsman should explain the situation fully to the complainant; suggest alternative remedies, before closing the case. If a complaint is substantiated by the ombudsman, facility staff should be informed of the complaint as soon as possible and encouraged to respond to the issue(s) raised. However, throughout the investigation and reporting processes, confidentiality and the integrity of the investigation must be maintained. Please refer to the OmbudsManager User Guide for data entry requirements.

Step Five: Resolution

Complaint resolution should be resident-centered and directed to the extent possible. This approach ensures that the complainant/resident's expectations and objectives are integral to the resolution. Problem resolution is authorized by Federal and District of Columbia statutes through utilization of the following:

- Negotiating with staff at the facility level to change a particular behavior, pattern, or practice affecting a resident(s);
- Educating a resident, family member, or facility personnel on ways to resolve a problem;
- Referring the situation to the DOH, DMH, or other outside agency for further action;
- Proposing regulatory or statutory changes or amendments to agency and government officials; and

- Communicating with community groups, professional organizations, and the media;
- Pursuing legal and administrative remedies on behalf of a resident and facilitating the utilization of legal services assistance by the complainant/ resident(s).

Recognizing that every complaint is capable of a resolution entirely satisfactory to the complainant/resident, the ombudsmen should exhaust all reasonable avenues of assistance to the complainant/resident, directly or by referral. If such efforts are unsuccessful, the ombudsman should advise the complainant(s) and provide the individual(s) with information on how to proceed independently.

The resolution process includes a 30-day follow-up of the complaint for the purpose of determining repetition, reoccurrence and systemic concerns.

Step Six: Closure

Once a complaint has been resolved, the record should be closed. All data for all cases must be entered into the database by the date established by the State Ombudsman. Please refer to the OmbudsManager User Guide for data entry requirements.

1.2. COORDINATION OF COMPLAINT INVESTIGATION ACTIVITIES

The intent of the Long-Term Care Ombudsman provisions of the Older Americans Act is to ensure a complaint investigation and resolution system that is responsive to the problems and concerns of persons who reside in long-term care facilities. The development of the capacity to undertake these activities under the Older Americans Act is in no way meant to relieve any other State Agency of any statutory responsibilities to respond to long-term care complaints, nor is it contemplated that unnecessary duplication of effort between the DCLTCOP and any other agency should occur.

The Office of the Long-Term Care Ombudsman is a representative of the long-term care resident. Its function is not to cite violations of the regulations, but an ombudsman, in investigating a complaint, may recognize regulatory deficiencies. The DLCTCOP uses licensing regulations of DOH, DMH and other appropriate agencies as referral sources and reports suspected violations of law or code requirements to these agencies.

The DCLTCOP, in efforts of collaboration, has established Memorandum of Agreements (MOAs) with DOH, DMH and DHCF for established inter-agency protocols. In addition, DCLTCOP has a Memorandum of Understanding (MOU) with D.C. Office on Aging, as it pertains to services provided to Medicaid Beneficiaries.

2.0. ACCESS TO FACILITIES, RESIDENTS AND RECORDS

The DCLTCOP requires access to facilities, residents, and records in order to perform two vital functions of the Office: (1) investigating/resolving complaints and (2) monitoring the quality of care provided in long-term care facilities. Both federal and District of Columbia laws are sources for the Ombudsman's authority to gain access to facilities, their residents, and facility and resident records. (See, Attachment F for federal law and Attachment G for District law)

Whenever the DCLTCOP staff or volunteers visit a long-term care facility to investigate a complaint or to monitor the facility, they must wear their official identification badge. When they enter the facility, they must sign their name, date, and time of day in the Ombudsman log (for CRFs/ALRs the visitors' log), which is generally kept at the front desk or entrance hall of the facility, and inform security or other staff that an ombudsman is in the building. This procedure serves to record the presence of a representative of the Ombudsman Office in the facility and to provide notification to the staff person in charge of the facility that an ombudsman is in the building.

When the DCLTCOP staff or volunteers go to a floor or unit of a nursing home, they should first go to the nursing station, introduce themselves to the staff at that station, and announce their presence. If no staff is present, the ombudsman or volunteer should continue making rounds and introduce themselves when staff is next observed. When Ombudsman Program staff or volunteers go to a floor or unit of an assisted living or community residence facility, they should also introduce themselves to any staff on duty.

The Ombudsman and his/her designees have access to any record that is necessary to carry out his or her responsibilities. They are afforded the same right as the Mayor to review, inspect or photocopy the records of a resident. In addition, privacy is to be provided in all communication between the resident and the Ombudsman and/or his designees.

The DCLTCOP has 24 hour/7 day a week access to all long-term care facilities in the District of Columbia. However, generally Ombudsman Program staff and volunteers visit facilities between the hours of 8:00 a.m. and 8:00 p.m. The reason(s) for and outcome(s) of late night visits should be documented in the OmbudsManager database.

2.1. DENIAL OF ACCESS

On occasion, the Ombudsman, or his or her designee(s), may be refused access to a facility, resident, and/or records through passive denial or overt denial. A passive denial results when there is no response by nursing home or community residence facility personnel to attempts by an ombudsman to gain access. In this situation, a

business card and/or a program brochure is left at the facility, and a follow-up telephone contact or visit is made. An overt denial occurs when an ombudsman is personally denied access to the facility. Unless circumstances dictate otherwise (e.g., the denial is of a visit in response to a complaint which appears to present an emergency or a potentially harmful situation or is part of a pattern of denials of access), at least one additional attempt to gain access will be made prior to petitioning the court for an order granting emergency access. The regulatory arm of DOH or DMH is informed about each instance of denied access.

3.0. TRAINING AND CERTIFICATION OF STAFF AND VOLUNTEERS

The District of Columbia Long -Term Care Ombudsman Program Act of 1988, D.C. Law 7-218, D.C. Code 7-702.04(a)(15) requires that the DCLTCOP establish and conduct a training program for all persons affiliated with the program. Staff and volunteers must complete classroom and field training before their assignment to a facility. The purpose of the DCLTCOP training component is to ensure that all staff and volunteers are thoroughly prepared to provide the best possible advocacy on behalf of District long-term care residents.

3.1. TRAINING OF VOLUNTEERS AND STAFF

For volunteers and staff, pre-service training consists of two full days (15 hours) of subject matter review followed by on-site visits to the nursing home at which the volunteer will serve. At the end of classroom training, a certificate of participation is presented to each attendee. Training methods may include lectures by guest speakers, panel discussions, videos, questions and answers, role plays, and case history presentations. Presenters may include consumer advocates, ombudsmen, lawyers, nursing home staff, nursing home residents, and current volunteer advocates.

The legally required subject areas for volunteers and staff must consist of the following:

- Reviewing medical records
- Regulatory requirements for long term care facilities
- Confidentiality of records
- Techniques of complaint investigation
- Effects of institutionalization
- Special needs of the elderly

Using the established training manual, the training specifically should include:

- Overview of the Ombudsman Program, the Older Americans Act, and the D.C. Aging Network;
- Characteristics, special needs, problems, and strengths of long term care facility residents and effects of institutionalization;
- Characteristics of nursing homes, assisted living and community residence facilities;
- Long-term care reimbursement system;

- Long-term care regulatory system;
- Complaint investigation, resolution, and advocacy skills;
- Problem identification;
- Residents' rights;
- Assertiveness and negotiation skills; and
- Confidentiality.

Chapter XI of the Technical Assistance Materials for State Long-Term Care Ombudsman Programs, prepared by the Federal Administration on Aging, discusses the importance of training ombudsman staff and volunteers.

The fundamental purpose of Ombudsman training is to impart to those working at all levels of the Ombudsman Program the basic skills and substantive knowledge necessary for them to carry out their responsibilities. It is imperative that all persons involved in complaint investigation and resolution receive such training, receive certification for having been trained and demonstrate competency in performing their assigned roles.

The recruitment and training of volunteers should be implemented annually by the DCLTCOP, but may occur more often if additional volunteer staff is needed. In addition, each volunteer is required to complete 12 hours of training per year provided by the DCLTCOP at monthly in-service training sessions.

The DCLTCOP staff meet monthly to discuss problems and changes in the long-term care system and to receive training in specific long-term advocacy issues. In addition, Ombudsman Program staff utilizes a range of training programs available in the community, as well as the annual meetings of such organizations as the National Consumer Voice for Quality Long-Term Care, the National Association of Protection and Advocacy Agencies, the National Council on Aging, the DC Bar and other advocacy organizations. Training sessions include the review of medical records, confidentiality, regulatory requirements, techniques of complaint investigation, dispute resolution, effects of institutionalization, restraint use, ethics, empowerment, and residents' rights. The training component of the DCLTCOP meets both federal and District requirements.

3.3. OMBUDSMAN DESIGNATION REQUIREMENTS

The Ombudsman and his/her designees must meet the following requirements:

- Completion of a minimum of 15 hours of training as described in 3.1 of this manual;
- Be employed by the D.C. Long-Term Care Ombudsman Office which funded by the D.C. Office on Aging funded by the D.C. Office on Aging;

- Certify that he or she has not been employed in an administrative capacity by a long-term care facility or a corporation that directly or indirectly owns or operates a long-term care facility within the past 2 years;
- Certify that he/she or any immediate family member does not have a pecuniary interest in a long-term care facility.

A designee can be either employee or volunteer of the DCLTCOP or “any person who has written authority to act on behalf of the Ombudsman pursuant to DC Code §7-702.04(a). (See, Attachment G)

3.4. DESIGNATION PROCESS

The D.C. Ombudsman submits the names of individuals for which she or he is requesting designation and their designation packages to the Executive Director of the D.C. Office on Aging for approval.

The designation package for each designee candidate includes verification of ombudsman training, verification of employment with Legal Counsel for the Elderly (LCE), resume of experience, certification the candidate has not been employed in an administrative capacity by a long-term care facility within the past two years, and certification the candidate does not have any pecuniary interest in a long-term care facility.

The Executive Director reviews the candidate's package and informs the D.C. Ombudsman in writing if the candidate has been approved or denied designation status.

Designee status is automatically revoked if the designee is no longer an employee of the Ombudsman Office. The Executive Director of the D.C. Office on Aging may also withdraw an individual's designation to perform the duties of a Long-Term Care Ombudsman when there is evidence that the designee (1) has failed to pass a criminal background check; (2) has failed to zealously protect the rights of any older person or of any long-term care facility resident and has not represented such individual's interests with undivided loyalty and without conflict of interest; (3) has failed to thoroughly and completely investigate and resolve complaints made by or on behalf of an older person or other person who is a long-term care facility resident; (4) has failed to perform his or her duties as an ombudsman under either federal or District law; (5) has abused, neglected or exploited, as defined in the D.C. Adult Protective Services Act of 1984, any older person or any resident of a long-term care facility; or (6) has engaged in conduct that is disruptive to the Long-Term Care Ombudsman Office, such as interfering with the Ombudsman's ability to address the needs of residents of long term care facilities by making unsubstantiated allegations of abuse, neglect, or exploitation.

When the Executive Director of the D.C. Office on Aging finds that grounds exist for withdrawing an individual's designation, written notification of such finding is sent to the designee, LCE, and to the D.C. Long-Term Care Ombudsman. The designee and the D.C. Ombudsman shall then have 15 calendar days from the date of receipt of such

findings to respond in writing to the DCOA Director's findings.

The DCOA Director shall issue any revised findings within 15 calendar days of the original receipt of the written responses. If the Director decides not to revise the initial findings, the determination withdrawing the designation becomes immediately effective upon a second notice. The Director shall issue a second notice within 15 calendar days of the receipt of the written responses, indicating that the initial determination is effective as of the date of the second notice.

4.0 CONFIDENTIALITY OF COMMUNICATIONS AND RECORDS

Federal law, section 129 of P. L. 100-175, amending section 308(b)(5) of the Older Americans Act of 1965, and the District of Columbia Long-Term Care Ombudsman Program Act of 1988, D.C. Law 7-218, D.C. Code §7-702.04(a)(17) requires the Ombudsman to maintain the strictest confidentiality concerning the identity, records, and statements of long term care residents. (See Attachment F and G)

All files, complaints, responses to complaints, and other information related to any complaint or investigation are considered confidential. No person who gains access to residents' records shall discuss or disclose information in the records or disclose a resident's identity outside of the DCLTCP. Any communication made to the Office of the D.C. Long-Term Care Ombudsman or to a local ombudsman program by a resident or complainant must be held in the strictest confidence and shall not be revealed without the expressed permission of the resident, the resident's representative, or complainant.

Any request made to the DCLTCOP by a representative of the media or by an outside attorney for information or records about a long-term care facility resident, investigation, or complaint shall be referred to the DCLTOP attorney. In addition, any oral presentation or written communication directed to providers, advocacy organizations, government agencies, or government officials by any Ombudsman Program staff or volunteer, that expresses an official policy or position of the Office of the D.C. Long-Term Care Ombudsman on any matter, must first be submitted to and approved by the D.C. Long-Term Care Ombudsman, and where appropriate, by the DCLTOP attorney.

Complainants and/or residents shall be informed of their right to remain anonymous throughout the complaint investigation process. The provisions of confidentiality apply to all staff and volunteers with the DCLTCOP. No complaint or other confidential information or records maintained by the DCLTCOP may be disclosed unless the D.C. Ombudsman authorizes the disclosure.

The D.C. Ombudsman shall not disclose the identity of any complainant, resident, or others providing information to an ombudsmen during the investigation of a complaint, unless:

- (a) the complainant or resident, or legal representative of either, consents to the disclosure and specifies to whom the identity may be disclosed, or

(b) a court orders the disclosure.

In the case of an incompetent resident, information is disclosed only to the extent necessary to resolve the complaint.

Inspection dates provided to the DCLTOP by the DOH and DMH are confidential under Federal and District law. Inspection dates and dates of unannounced visits to long-term care facilities by the DOH and DMH, including visits for the purpose of complaint investigation, are also confidential and shall not be revealed by any Ombudsman Office staff.

Privacy shall be provided for receipt of complaints by mail, telephone, or personal interview in order to maintain confidentiality. All mail addressed to an ombudsman by name or title shall be delivered unopened to the ombudsman. Locked files shall be used to maintain confidential records. Access to such files is limited to staff of the Office of the D.C. Long -Term Care Ombudsman.

Because the Office of the D.C. Long-Term Care Ombudsman is authorized by law to pursue legal and administrative matters on behalf of residents, the ombudsmen may consult with and/or refer matters to attorneys at Legal Counsel for the Elderly and to private attorneys. However, any communication between an ombudsman and a private attorney about a resident should take place only after discussion of the matter with, and advice of, counsel for the DCLTCOP, and the Ombudsman Office's counsel should be present at any meeting between an ombudsman and private attorney that concerns an ombudsman investigation. The District of Columbia Bar's Code of Professional Responsibility governs matters concerning the attorney/client relationship, be it between an ombudsman and his/her counsel, or a client and counsel. The Code of Professional Responsibility also applies to matters referred by the Ombudsman Office to private attorneys.

The records of the Office of the District of Columbia Long -Term Care Ombudsman are not public information and are not discoverable under the Federal or D.C. Freedom of Information Act. In addition, access to the records cannot be granted by any person or entity other than the D.C. Ombudsman.

5.0. CODE OF ETHICS

In all endeavors, the DCLTCOP works to promote:

- each resident's right to self-determination,
- each resident's optimal level of functioning and independence,
- each resident's informed participation in decision making by all members of the long-term care community, and
- the protection of vulnerable individuals.

The primary responsibility of the DCLTCOP is to promote residents' rights and well-being. Ombudsman Office staff are guided in this endeavor by the residents' wishes concerning the manner in which a complaint is to be resolved and the degree of anonymity to be maintained.

The Ombudsman Office safeguards the residents' right to privacy by protecting information. All complaints brought to the attention of an ombudsman are confidential and can be discussed only with persons who are authorized to assist with their resolution. The name of the complainant or resident will not be revealed or included in a referral to another agency unless the complainant or resident has specifically granted permission for his or her name to be disclosed.

The DCLTCOP provides advocacy services unrestricted by personal beliefs or opinions and without regard to age, social or economic status, personal characteristics, race, sex, marital status or sexual preference. The Ombudsman Office respects and promotes a resident's right to self-determination and makes every effort to determine and act in accordance with the resident's wishes. The resident or potential resident is considered to be the client of the Ombudsman Office, regardless of who contacts the program.

Ombudsman staff and volunteers act in accordance with the standards, practices, policies and procedures of the D.C. Long-Term Care Ombudsman Office. Each ombudsman upholds his/her legal and professional responsibility to act on behalf of vulnerable individuals, and each maintains competence in areas relevant to the long-term care system such as regulatory and legislative changes and long-term care service options.

Attachment A:

Complaint Acknowledgement Letter

Attachment A:

D.C. Long-Term Care Ombudsman Program

601 E Street, N.W.
Building A – 4th Floor
Washington, D.C. 20049

Date:

Dear: _____,

The D.C. Long-Term Care Ombudsman Program acknowledges the receipt of your written complaint. The complaint will be investigated.

At the conclusion of the investigation, the Ombudsman Program will communicate to you whether the complaint was verified or not and whether it was referred to any other District agencies for further investigation and/or regulatory action.

Thank you for your interest and concern for long-term care residents in the District of Columbia.

Sincerely,

(signature of ombudsman name)

(type name of the ombudsman, and the program)

Attachment B:

Monthly Visit Schedule Form

Attachment B:

D.C. Long-Term Care Ombudsman Nursing Home Monthly Visit Schedule

Date of Visit	Name and Address of Facility	Approx. Time Spent on Visitation	Late Recorded Visitation Date

Signature of Ombudsman:_____.

Signature of Ombudsman's Manager:_____.

Attachment C:

Consent Form

Attachment C:

D.C. Long-Term Care Ombudsman Program
Authorization for Release of Confidential Information

1. Resident: _____

2. Authorized Agent/Organization(s): _____

I, _____, authorize the above named agent organization to release information contained in my records to individual(s) and to disclose my name and residence to the organization listed below:

DC Long-Term Care Ombudsman Program
601 E St. NW
Washington, DC 20049
Office #: 202-434-2190 Fax#: 202-434-6595

This authorization has been given by __ oral and/or __ written consent. The records that may be released by the facility/agency named above include, but are not limited to, the following: medical/psychiatric records, any and all incident reports, progress notes, nurses' records, photographs (taken by facility, other agency or Ombudsman Program) doctors' orders, financial records, (for example: fees for services, contracts, rent to facility, benefit income, or additional medical fees not related to facility).

I authorize my healthcare providers and their staff to discuss my condition and treatment with the staff of the Ombudsman Program. The purpose for such disclosure is to investigate and report, if necessary, concerns and complaints on my behalf and to represent my interests in any legal proceedings. I understand that this might require the disclosure by the Ombudsman Program of name, residence and concerns to regulatory or enforcement authorities or other appropriate parties. I understand that this authorization, except for action already taken, may be voided by me at any time, verbally or in writing. This consent (unless expressly revoked earlier) expires one year from date of signature below. I also consent to allow copies of this release to be made and for copies to constitute a valid release.

Signature of Resident

Date

Signature of Resident's Representative
(if needed)

Date

Attachment D:

Complaint Intake Form

Attachment D:

Complaint Intake Forms

**DISTRICT OF COLUMBIA LONG TERM CARE OMBUDSMAN PROGRAM
CASE INTAKE FORM**

STATE CODE: 09 DC CASE# _____
OMBUDSMAN ID: _____
FACILITY NAME: _____ Facility Code _____
COMPLAINANT'S NAME: _____
Complainant's Address: _____
Complainant's Phone: H(_____) W(_____) _____
Complainant's Relationship to Resident: CODE # _____ *(See Below) Family Relation: _____
*1- Resident 2-Family/Friend 3- Non-relative guardian/legal representative 4-Ombudsman
5-Facility/provider administrator/staff 6- medical person, i.e. physician staff 7-Representative of other
social service agency or program 8-Unknown 9-other
May Name of Complainant be revealed? _____ Comments: _____

DATE INCIDENT OCCURRED: _____ TIME or SHIFT _____ am/pm(circle) ONGOING _____

RESIDENT'S NAME: _____ AGE: _____
(Last Name) (First Name) (Middle Initial)

RESIDENT'S GENDER _____	RACE _____	PAY STATUS _____
1-Male 2-Female	1-African-American 2-Asian	1-Medicare 2) Medicaid
	3-Caucasian 4-Hispanic	3-Medicare & Medicaid
	5-Native American Indian	4-Private Pay/insurance
	6-Unknown/ill/fault 7-Other	5-VA 6-Other

INTAKE DATE: _____ BY: Phone _____ Letter _____ FAX _____ Personal Contact _____

CONSENT for Ombudsman Action: Verbal _____ Written _____

DATE RECEIVED: ____/____/____ DATE OF FIRST ACTION: ____/____/____

DATE REFERRED: ____/____/____ DATE INT. RES: ____/____/____

DATE FINAL RES.: ____/____/____ 30 DAY FOLLOW-UP: ____/____/____

DATE CASE CLOSED: ____/____/____

STATEMENT OF COMPLAINT(S):
Narrative:

CASE Intake Form Completed By: _____

COMPLAINT CATEGORY CODES: (refer to code sheet from AOA*)

* _____ * _____ * _____ * _____ * _____ * _____ * _____ * _____ * _____
12/01

Case No. _____

DISTRICT OF COLUMBIA LONG TERM CARE OMBUDSMAN
INTAKE PROGRESS NOTES

Facility _____ Resident _____

Type of Contact *	Entry	Time Min	Initials

*FV - Facility Visit
TC- Telephone Contact

Page # _____ of _____

Attachment E:

Complaint Referral Form

ATTACHMENT E:**Complaint Referral Form**

Date: / /	OFFICE OF THE D.C. LONG TERM CARE OMBUDSMAN PROGRAM Legal Counsel for the Elderly 601 E Street, N.W. Washington, DC 20049 (202) 434-2190 (202) 434-6595 fax
Fax To:	
From:	
# of Pages	

Tracking # _____ Today's Date: / /

URGENT ☐

Date of Referral: / /

Important ☐By Phone: ☐FYI ☐By Fax: ☐By Mail: ☐

LTC Ombudsman _____ Phone: () -

Fax: () -

Name of Facility: _____

Resident's Name: _____

Address: _____

Room Number: _____

Date of Visit: / / Date Complaint Occurred: / /

Referred to:☐ HRA (202) 442-9431 fax

Contact name _____

☐ APS (202) 541-3964 fax

Contact name _____

☐ MFCU (202) 727-5937 fax

Contact name _____

☐ SMPP

Contact name _____

☐ Law Enforcement

Contact name _____

☐ Other: _____

Contact name _____

Agency Case # _____

Follow-up Date: _____

Attachment F:
Federal Law

- Older Americans Act
- Nursing Home Reform Act

Attachment F1:
Older Americans Act

(A) the results of the study conducted under this subsection; and

(B) recommendations for future actions to combat the financial exploitation of older individuals.

(h) Accountability measures

The Assistant Secretary shall develop accountability measures to ensure the effectiveness of the activities carried out under this section.

(i) Evaluating programs

The Assistant Secretary shall evaluate the activities carried out under this section, using funds made available under section 3017(g) of this title.

(j) Compliance with applicable laws

In order to receive funds made available to carry out this section, an entity shall comply with all applicable laws, regulations, and guidelines.

(Pub. L. 89-73, title VII, § 721, as added Pub. L. 102-375, title VII, § 703(b), Sept. 30, 1992, 106 Stat. 1282; amended Pub. L. 106-501, title VII, § 705, title VIII, § 801(e)(3), Nov. 13, 2000, 114 Stat. 2290, 2293; Pub. L. 109-365, title VII, § 702, Oct. 17, 2006, 120 Stat. 2591.)

AMENDMENTS

2006—Subsec. (a). Pub. L. 109-365, § 702(1), substituted “programs to address” for “programs for the prevention of”.

Subsec. (b). Pub. L. 109-365, § 702(2)(A), substituted “programs for the prevention, detection, assessment, and treatment of, intervention in, investigation of, and response to elder abuse, neglect, and exploitation (including financial exploitation), including—” for “programs for the prevention and treatment of elder abuse, neglect, and exploitation (including financial exploitation), including—” in introductory provisions.

Subsec. (b)(2) to (9). Pub. L. 109-365, § 702(2)(B), (C), added par. (2) and redesignated former pars. (2) to (8) as (3) to (9), respectively.

Subsec. (b)(10) to (12). Pub. L. 109-365, § 702(2)(D)–(F), added pars. (10) to (12).

Subsec. (e)(2). Pub. L. 109-365, § 702(3), substituted “subsection (b)(9)(B)(i)” for “subsection (b)(8)(B)(i)” and “subsection (b)(9)(B)(ii)” for “subsection (b)(8)(B)(ii)”.

Subsecs. (h) to (j). Pub. L. 109-365, § 702(4), added subsecs. (h) to (j).

2000—Subsec. (a). Pub. L. 106-501, § 801(e)(3), substituted “section 3058a of this title and made available to carry out this subpart” for “section 3058a(b) of this title”.

Subsec. (b). Pub. L. 106-501, § 705(1)(A), in introductory provisions, inserted “(including financial exploitation)” after “exploitation”.

Subsec. (b)(2). Pub. L. 106-501, § 705(1)(B), inserted “, State and local law enforcement systems, and courts of competent jurisdiction” after “service program”.

Subsec. (b)(5). Pub. L. 106-501, § 705(1)(C), inserted “including caregivers described in part E of subchapter III of this chapter,” after “individuals,”.

Subsec. (d)(8). Pub. L. 106-501, § 705(2), inserted “State and local” before “law enforcement programs” and “, and services provided by agencies and courts of competent jurisdiction” before period at end.

Subsec. (g). Pub. L. 106-501, § 705(3), added subsec. (g).

DECLARATION OF PURPOSE

Section 703(a) of Pub. L. 102-375 provided that: “The purpose of this section [enacting this subpart] is to assist States in the design, development, and coordina-

tion of comprehensive services of the State and local levels to prevent, treat, and remedy elder abuse, neglect, and exploitation.”

SUBPART IV—STATE LEGAL ASSISTANCE DEVELOPMENT PROGRAM

§ 3058j. State legal assistance development

A State agency shall provide the services of an individual who shall be known as a State legal assistance developer, and the services of other personnel, sufficient to ensure—

(1) State leadership in securing and maintaining the legal rights of older individuals;

(2) State capacity for coordinating the provision of legal assistance;

(3) State capacity to provide technical assistance, training, and other supportive functions to area agencies on aging, legal assistance providers, ombudsmen, and other persons, as appropriate;

(4) State capacity to promote financial management services to older individuals at risk of conservatorship;

(5) State capacity to assist older individuals in understanding their rights, exercising choices, benefiting from services and opportunities authorized by law, and maintaining the rights of older individuals at risk of guardianship; and

(6) State capacity to improve the quality and quantity of legal services provided to older individuals.

(Pub. L. 89-73, title VII, § 731, as added Pub. L. 106-501, title VII, § 706, Nov. 13, 2000, 114 Stat. 2291.)

PRIOR PROVISIONS

A prior section 3058j, Pub. L. 89-73, title VII, § 731, as added Pub. L. 102-375, title VII, § 704, Sept. 30, 1992, 106 Stat. 1285, related to State elder rights and legal assistance development, prior to repeal by Pub. L. 106-501, title VII, § 706, Nov. 13, 2000, 114 Stat. 2291.

SUBPART V—OUTREACH, COUNSELING, AND ASSISTANCE PROGRAM

§ 3058k. Repealed. Pub. L. 106-501, title VII, § 706, Nov. 13, 2000, 114 Stat. 2291

Section, Pub. L. 89-73, title VII, § 741, as added Pub. L. 102-375, title VII, § 705(b), Sept. 30, 1992, 106 Stat. 1287; amended Pub. L. 103-171, § 3(a)(13), Dec. 2, 1993, 107 Stat. 1990, related to State outreach, counseling, and assistance program for insurance and public benefits.

PART B—NATIVE AMERICAN ORGANIZATION AND ELDER JUSTICE PROVISIONS

§ 3058aa. Native American program

(a) Establishment

The Assistant Secretary, acting through the Director of the Office for American Indian, Alaskan Native, and Native Hawaiian Aging, shall establish and carry out a program for—

(1) assisting eligible entities in prioritizing, on a continuing basis, the needs of the service population of the entities relating to elder rights;

(2) making grants to eligible entities to carry out vulnerable elder rights protection activities that the entities determine to be priorities; and

ious safe haven models for establishing safe havens (at home or elsewhere), that recognize autonomy and self-determination, and fully protect the due process rights of older individuals;

(11) supporting multidisciplinary elder justice activities, such as—

(A) supporting and studying team approaches for bringing a coordinated multidisciplinary or interdisciplinary response to elder abuse, neglect, and exploitation, including a response from individuals in social service, health care, public safety, and legal disciplines;

(B) establishing a State coordinating council, which shall identify the individual State's needs and provide the Assistant Secretary with information and recommendations relating to efforts by the State to combat elder abuse, neglect, and exploitation;

(C) providing training, technical assistance, and other methods of support to groups carrying out multidisciplinary efforts at the State (referred to in some States as "State Working Groups");

(D) broadening and studying various models for elder fatality and serious injury review teams, to make recommendations about their composition, protocols, functions, timing, roles, and responsibilities, with a goal of producing models and information that will allow for replication based on the needs of States and communities (other than the ones in which the review teams were used); and

(E) developing best practices, for use in long-term care facilities, that reduce the risk of elder abuse for residents, including the risk of resident-to-resident abuse; and

(12) addressing underserved populations of older individuals, such as—

(A) older individuals living in rural locations;

(B) older individuals in minority populations; or

(C) low-income older individuals.

(c) Approach

In developing and enhancing programs under subsection (a) of this section, the State agency shall use a comprehensive approach, in consultation with area agencies on aging, to identify and assist older individuals who are subject to abuse, neglect, and exploitation, including older individuals who live in State licensed facilities, unlicensed facilities, or domestic or community-based settings.

(d) Coordination

In developing and enhancing programs under subsection (a) of this section, the State agency shall coordinate the programs with other State and local programs and services for the protection of vulnerable adults, particularly vulnerable older individuals, including programs and services such as—

(1) area agency on aging programs;

(2) adult protective service programs;

(3) the State Long-Term Care Ombudsman program established in subpart II of this part;

(4) protection and advocacy programs;

(5) facility and long-term care provider licensure and certification programs;

(6) medicaid fraud and abuse services, including services provided by a State medicaid fraud control unit, as defined in section 1396b(q) of this title;

(7) victim assistance programs; and

(8) consumer protection and State and local law enforcement programs, as well as other State and local programs that identify and assist vulnerable older individuals, and services provided by agencies and courts of competent jurisdiction.

(e) Requirements

In developing and enhancing programs under subsection (a) of this section, the State agency shall—

(1) not permit involuntary or coerced participation in such programs by alleged victims, abusers, or members of their households;

(2) require that all information gathered in the course of receiving a report described in subsection (b)(9)(B)(i) of this section, and making a referral described in subsection (b)(9)(B)(ii) of this section, shall remain confidential except—

(A) if all parties to such complaint or report consent in writing to the release of such information;

(B) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or

(C) upon court order; and

(3) make all reasonable efforts to resolve any conflicts with other public agencies with respect to confidentiality of the information described in paragraph (2) by entering into memoranda of understanding that narrowly limit disclosure of information, consistent with the requirement described in paragraph (2).

(f) Designation

The State agency may designate a State entity to carry out the programs and activities described in this subpart.

(g) Study and report

(1) Study

The Secretary, in consultation with the Department of the Treasury and the Attorney General of the United States, State attorneys general, and tribal and local prosecutors, shall conduct a study of the nature and extent of financial exploitation of older individuals. The purpose of this study would be to define and describe the scope of the problem of financial exploitation of the elderly and to provide an estimate of the number and type of financial transactions considered to constitute financial exploitation faced by older individuals. The study shall also examine the adequacy of current Federal and State legal protections to prevent such exploitation.

(2) Report

Not later than 18 months after November 13, 2000, the Secretary shall submit to Congress a report, which shall include—

(Pub. L. 89-73, title VII, §713, as added Pub. L. 102-375, title VII, §702, Sept. 30, 1992, 106 Stat. 1282; amended Pub. L. 103-171, §3(a)(13), Dec. 2, 1993, 107 Stat. 1990.)

AMENDMENTS

1993—Pub. L. 103-171 substituted "Assistant Secretary" for "Commissioner".

SUBPART III—PROGRAMS FOR PREVENTION OF ELDER ABUSE, NEGLECT, AND EXPLOITATION

§ 3058i. Prevention of elder abuse, neglect, and exploitation

(a) Establishment

In order to be eligible to receive an allotment under section 3058b of this title from funds appropriated under section 3058a of this title and made available to carry out this subpart, a State agency shall, in accordance with this section, and in consultation with area agencies on aging, develop and enhance programs to address elder abuse, neglect, and exploitation.

(b) Use of allotments

The State agency shall use an allotment made under subsection (a) of this section to carry out, through the programs described in subsection (a) of this section, activities to develop, strengthen, and carry out programs for the prevention, detection, assessment, and treatment of, intervention in, investigation of, and response to elder abuse, neglect, and exploitation (including financial exploitation), including—

- (1) providing for public education and outreach to identify and prevent elder abuse, neglect, and exploitation;
- (2) providing for public education and outreach to promote financial literacy and prevent identity theft and financial exploitation of older individuals;
- (3) ensuring the coordination of services provided by area agencies on aging with services instituted under the State adult protection service program, State and local law enforcement systems, and courts of competent jurisdiction;
- (4) promoting the development of information and data systems, including elder abuse reporting systems, to quantify the extent of elder abuse, neglect, and exploitation in the State;
- (5) conducting analyses of State information concerning elder abuse, neglect, and exploitation and identifying unmet service, enforcement, or intervention needs;
- (6) conducting training for individuals, including caregivers described in part E of subchapter III of this chapter, professionals, and paraprofessionals, in relevant fields on the identification, prevention, and treatment of elder abuse, neglect, and exploitation, with particular focus on prevention and enhancement of self-determination and autonomy;
- (7) providing technical assistance to programs that provide or have the potential to provide services for victims of elder abuse, neglect, and exploitation and for family members of the victims;
- (8) conducting special and on-going training, for individuals involved in serving victims of

elder abuse, neglect, and exploitation, on the topics of self-determination, individual rights, State and Federal requirements concerning confidentiality, and other topics determined by a State agency to be appropriate;

(9) promoting the development of an elder abuse, neglect, and exploitation system—

(A) that includes a State elder abuse, neglect, and exploitation law that includes provisions for immunity, for persons reporting instances of elder abuse, neglect, and exploitation, from prosecution arising out of such reporting, under any State or local law;

(B) under which a State agency—

(i) on receipt of a report of known or suspected instances of elder abuse, neglect, or exploitation, shall promptly initiate an investigation to substantiate the accuracy of the report; and

(ii) on a finding of elder abuse, neglect, or exploitation, shall take steps, including appropriate referral, to protect the health and welfare of the abused, neglected, or exploited older individual;

(C) that includes, throughout the State, in connection with the enforcement of elder abuse, neglect, and exploitation laws and with the reporting of suspected instances of elder abuse, neglect, and exploitation—

(i) such administrative procedures;

(ii) such personnel trained in the special problems of elder abuse, neglect, and exploitation prevention and treatment;

(iii) such training procedures;

(iv) such institutional and other facilities (public and private); and

(v) such related multidisciplinary programs and services,

as may be necessary or appropriate to ensure that the State will deal effectively with elder abuse, neglect, and exploitation cases in the State;

(D) that preserves the confidentiality of records in order to protect the rights of older individuals;

(E) that provides for the cooperation of law enforcement officials, courts of competent jurisdiction, and State agencies providing human services with respect to special problems of elder abuse, neglect, and exploitation;

(F) that enables an older individual to participate in decisions regarding the welfare of the older individual, and makes the least restrictive alternatives available to an older individual who is abused, neglected, or exploited; and

(G) that includes a State clearinghouse for dissemination of information to the general public with respect to—

(i) the problems of elder abuse, neglect, and exploitation;

(ii) the facilities described in subparagraph (C)(iv); and

(iii) prevention and treatment methods available to combat instances of elder abuse, neglect, and exploitation;

(10) examining various types of shelters serving older individuals (in this paragraph referred to as "safe havens"), and testing var-

(A) specify a minimum number of hours of initial training;

(B) specify the content of the training, including training relating to—

- (i) Federal, State, and local laws, regulations, and policies, with respect to long-term care facilities in the State;
- (ii) investigative techniques; and
- (iii) such other matters as the State determines to be appropriate; and

(C) specify an annual number of hours of in-service training for all designated representatives;

(5) prohibit any representative of the Office (other than the Ombudsman) from carrying out any activity described in subparagraphs (A) through (G) of subsection (a)(3) of this section unless the representative—

(A) has received the training required under paragraph (4); and

(B) has been approved by the Ombudsman as qualified to carry out the activity on behalf of the Office;

(6) coordinate ombudsman services with the protection and advocacy systems for individuals with developmental disabilities and mental illnesses established under—

(A) subtitle C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 [42 U.S.C. 15041 et seq.]; and

(B) the Protection and Advocacy for Mentally Ill Individuals Act of 1986³ (42 U.S.C. 10801 et seq.);

(7) coordinate, to the greatest extent possible, ombudsman services with legal assistance provided under section 3026(a)(2)(C) of this title, through adoption of memoranda of understanding and other means;

(8) coordinate services with State and local law enforcement agencies and courts of competent jurisdiction; and

(9) permit any local Ombudsman entity to carry out the responsibilities described in paragraph (1), (2), (3), (6), or (7).

(i) Liability

The State shall ensure that no representative of the Office will be liable under State law for the good faith performance of official duties.

(j) Noninterference

The State shall—

(1) ensure that willful interference with representatives of the Office in the performance of the official duties of the representatives (as defined by the Assistant Secretary) shall be unlawful;

(2) prohibit retaliation and reprisals by a long-term care facility or other entity with respect to any resident, employee, or other person for filing a complaint with, providing information to, or otherwise cooperating with any representative of, the Office; and

(3) provide for appropriate sanctions with respect to the interference, retaliation, and reprisals.

(Pub. L. 89-73, title VII, §712, as added Pub. L. 102-375, title VII, §702, Sept. 30, 1992, 106 Stat.

1276; amended Pub. L. 103-171, §3(a)(9), Dec. 2, 1993, 107 Stat. 1990; Pub. L. 106-402, title IV, §401(b)(9)(D), Oct. 30, 2000, 114 Stat. 1739; Pub. L. 106-501, title VII, §704, title VIII, §801(e)(2), Nov. 13, 2000, 114 Stat. 2289, 2293.)

REFERENCES IN TEXT

Section 3012(a)(21) of this title, referred to in subsec. (c)(2)(D), was redesignated section 3012(a)(18) of this title by Pub. L. 106-501, title II, §201(1)(B), Nov. 13, 2000, 114 Stat. 2229.

The Developmental Disabilities Assistance and Bill of Rights Act of 2000, referred to in subsec. (h)(6)(A), is Pub. L. 106-402, Oct. 30, 2000, 114 Stat. 1677. Subtitle C of the Act probably means subtitle C of title I of the Act, which is classified generally to part C (§15041 et seq.) of subchapter I of chapter 144 of this title. For complete classification of this Act to the Code, see Short Title note set out under section 15001 of this title and Tables.

The Protection and Advocacy for Mentally Ill Individuals Act of 1986, referred to in subsec. (h)(6)(B), was Pub. L. 99-319, May 23, 1986, 100 Stat. 478, as amended. Pub. L. 99-319 was renamed the Protection and Advocacy for Individuals with Mental Illness Act by Pub. L. 106-310, div. B, title XXXII, §3206(a), Oct. 17, 2000, 114 Stat. 1193, and is classified generally to chapter 114 (§10801 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 10801 of this title and Tables.

AMENDMENTS

2000—Subsec. (a)(1). Pub. L. 106-501, §801(e)(2), substituted "section 3058a of this title and made available to carry out this subpart" for "section 3058a(a) of this title" in introductory provisions.

Subsec. (a)(5)(C)(ii). Pub. L. 106-501, §704(1), inserted "and not stand to gain financially through an action or potential action brought on behalf of individuals the Ombudsman serves" after "interest".

Subsec. (h)(4). Pub. L. 106-501, §704(2)(A), substituted "strengthen and update" for "(A) not later than 1 year after September 30, 1992, establish" in introductory provisions, redesignated cls. (i) and (ii) of former subpar. (A) as subpars. (A) and (B), respectively, redesignated subcls. (I) to (III) of former subpar. (A)(ii) as cls. (i) to (iii), respectively, of subpar. (B), redesignated cl. (iii) of former subpar. (A) as subpar. (C) and struck out "and" at end, and struck out former subpar. (B) which read as follows: "require implementation of the procedures not later than 21 months after September 30, 1992;"

Subsec. (h)(6)(A). Pub. L. 106-402 substituted "subtitle C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000" for "part A of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 6001 et seq.)".

Subsec. (h)(8), (9). Pub. L. 106-501, §704(2)(B)-(D), added par. (8) and redesignated former par. (8) as (9).

1993—Subsecs. (a)(3)(I), (c)(2)(C), (h)(3)(B). Pub. L. 103-171, §3(a)(9)(B), substituted "Assistant Secretary" for "Commissioner".

Subsec. (h)(4)(A). Pub. L. 103-171, §3(a)(9)(A), substituted "Director of the Office of Long-Term Care Ombudsman Programs" for "Associate Commissioner for Ombudsman Programs".

Subsec. (j)(1). Pub. L. 103-171, §3(a)(9)(B), substituted "Assistant Secretary" for "Commissioner".

§ 3058h. Regulations

The Assistant Secretary shall issue and periodically update regulations respecting—

(1) conflicts of interest by persons described in paragraphs (1) and (2) of section 3058g(f) of this title; and

(2) the relationships described in subparagraphs (A) through (D) of section 3058g(f)(3) of this title.

³ See References in Text note below.

representative of the Office in accordance with such requirements as the State agency shall establish; or

(iii) the disclosure is required by court order.

(e) Consultation

In planning and operating the program, the State agency shall consider the views of area agencies on aging, older individuals, and providers of long-term care.

(f) Conflict of interest

The State agency shall—

(1) ensure that no individual, or member of the immediate family of an individual, involved in the designation of the Ombudsman (whether by appointment or otherwise) or the designation of an entity designated under subsection (a)(5) of this section, is subject to a conflict of interest;

(2) ensure that no officer or employee of the Office, representative of a local Ombudsman entity, or member of the immediate family of the officer, employee, or representative, is subject to a conflict of interest;

(3) ensure that the Ombudsman—

(A) does not have a direct involvement in the licensing or certification of a long-term care facility or of a provider of a long-term care service;

(B) does not have an ownership or investment interest (represented by equity, debt, or other financial relationship) in a long-term care facility or a long-term care service;

(C) is not employed by, or participating in the management of, a long-term care facility; and

(D) does not receive, or have the right to receive, directly or indirectly, remuneration (in cash or in kind) under a compensation arrangement with an owner or operator of a long-term care facility; and

(4) establish, and specify in writing, mechanisms to identify and remove conflicts of interest referred to in paragraphs (1) and (2), and to identify and eliminate the relationships described in subparagraphs (A) through (D) of paragraph (3), including such mechanisms as—

(A) the methods by which the State agency will examine individuals, and immediate family members, to identify the conflicts; and

(B) the actions that the State agency will require the individuals and such family members to take to remove such conflicts.

(g) Legal counsel

The State agency shall ensure that—

(1)(A) adequate legal counsel is available, and is able, without conflict of interest, to—

(i) provide advice and consultation needed to protect the health, safety, welfare, and rights of residents; and

(ii) assist the Ombudsman and representatives of the Office in the performance of the official duties of the Ombudsman and representatives; and

(B) legal representation is provided to any representative of the Office against whom suit

or other legal action is brought or threatened to be brought in connection with the performance of the official duties of the Ombudsman or such a representative; and

(2) the Office pursues administrative, legal, and other appropriate remedies on behalf of residents.

(h) Administration

The State agency shall require the Office to—

(1) prepare an annual report—

(A) describing the activities carried out by the Office in the year for which the report is prepared;

(B) containing and analyzing the data collected under subsection (c) of this section;

(C) evaluating the problems experienced by, and the complaints made by or on behalf of, residents;

(D) containing recommendations for—

(i) improving quality of the care and life of the residents; and

(ii) protecting the health, safety, welfare, and rights of the residents;

(E)(i) analyzing the success of the program including success in providing services to residents of board and care facilities and other similar adult care facilities; and

(ii) identifying barriers that prevent the optimal operation of the program; and

(F) providing policy, regulatory, and legislative recommendations to solve identified problems, to resolve the complaints, to improve the quality of care and life of residents, to protect the health, safety, welfare, and rights of residents, and to remove the barriers;

(2) analyze, comment on, and monitor the development and implementation of Federal, State, and local laws, regulations, and other government policies and actions that pertain to long-term care facilities and services, and to the health, safety, welfare, and rights of residents, in the State, and recommend any changes in such laws, regulations, and policies as the Office determines to be appropriate;

(3)(A) provide such information as the Office determines to be necessary to public and private agencies, legislators, and other persons, regarding—

(i) the problems and concerns of older individuals residing in long-term care facilities; and

(ii) recommendations related to the problems and concerns; and

(B) make available to the public, and submit to the Assistant Secretary, the chief executive officer of the State, the State legislature, the State agency responsible for licensing or certifying long-term care facilities, and other appropriate governmental entities, each report prepared under paragraph (1);

(4) strengthen and update procedures for the training of the representatives of the Office, including unpaid volunteers, based on model standards established by the Director of the Office of Long-Term Care Ombudsman Programs, in consultation with representatives of citizen groups, long-term care providers, and the Office, that—

protect the health, safety, welfare, and rights of the residents;

(v)(I) review, and if necessary, comment on any existing and proposed laws, regulations, and other government policies and actions, that pertain to the rights and well-being of residents; and

(II) facilitate the ability of the public to comment on the laws, regulations, policies, and actions;

(vi) support the development of resident and family councils; and

(vii) carry out other activities that the Ombudsman determines to be appropriate.

(C) Eligibility for designation

Entities eligible to be designated as local Ombudsman entities, and individuals eligible to be designated as representatives of such entities, shall—

(i) have demonstrated capability to carry out the responsibilities of the Office;

(ii) be free of conflicts of interest and not stand to gain financially through an action or potential action brought on behalf of individuals the Ombudsman serves;

(iii) in the case of the entities, be public or nonprofit private entities; and

(iv) meet such additional requirements as the Ombudsman may specify.

(D) Policies and procedures

(i) In general

The State agency shall establish, in accordance with the Office, policies and procedures for monitoring local Ombudsman entities designated to carry out the duties of the Office.

(ii) Policies

In a case in which the entities are grantees, or the representatives are employees, of area agencies on aging, the State agency shall develop the policies in consultation with the area agencies on aging. The policies shall provide for participation and comment by the agencies and for resolution of concerns with respect to case activity.

(iii) Confidentiality and disclosure

The State agency shall develop the policies and procedures in accordance with all provisions of this part regarding confidentiality and conflict of interest.

(b) Procedures for access

(1) In general

The State shall ensure that representatives of the Office shall have—

(A) access to long-term care facilities and residents;

(B)(i) appropriate access to review the medical and social records of a resident, if—

(I) the representative has the permission of the resident, or the legal representative of the resident; or

(II) the resident is unable to consent to the review and has no legal representative; or

(ii) access to the records as is necessary to investigate a complaint if—

(I) a legal guardian of the resident refuses to give the permission;

(II) a representative of the Office has reasonable cause to believe that the guardian is not acting in the best interests of the resident; and

(III) the representative obtains the approval of the Ombudsman;

(C) access to the administrative records, policies, and documents, to which the residents have, or the general public has access, of long-term care facilities; and

(D) access to and, on request, copies of all licensing and certification records maintained by the State with respect to long-term care facilities.

(2) Procedures

The State agency shall establish procedures to ensure the access described in paragraph (1).

(c) Reporting system

The State agency shall establish a statewide uniform reporting system to—

(1) collect and analyze data relating to complaints and conditions in long-term care facilities and to residents for the purpose of identifying and resolving significant problems; and

(2) submit the data, on a regular basis, to—

(A) the agency of the State responsible for licensing or certifying long-term care facilities in the State;

(B) other State and Federal entities that the Ombudsman determines to be appropriate;

(C) the Assistant Secretary; and

(D) the National Ombudsman Resource Center established in section 3012(a)(21)² of this title.

(d) Disclosure

(1) In general

The State agency shall establish procedures for the disclosure by the Ombudsman or local Ombudsman entities of files maintained by the program, including records described in subsection (b)(1) or (c) of this section.

(2) Identity of complainant or resident

The procedures described in paragraph (1) shall—

(A) provide that, subject to subparagraph (B), the files and records described in paragraph (1) may be disclosed only at the discretion of the Ombudsman (or the person designated by the Ombudsman to disclose the files and records); and

(B) prohibit the disclosure of the identity of any complainant or resident with respect to whom the Office maintains such files or records unless—

(i) the complainant or resident, or the legal representative of the complainant or resident, consents to the disclosure and the consent is given in writing;

(ii)(I) the complainant or resident gives consent orally; and

(II) the consent is documented contemporaneously in a writing made by a rep-

²See References in Text note below.

(A) specify a minimum number of hours of initial training;

(B) specify the content of the training, including training relating to—

(i) Federal, State, and local laws, regulations, and policies, with respect to long-term care facilities in the State;

(ii) investigative techniques; and

(iii) such other matters as the State determines to be appropriate; and

(C) specify an annual number of hours of in-service training for all designated representatives;

(5) prohibit any representative of the Office (other than the Ombudsman) from carrying out any activity described in subparagraphs (A) through (G) of subsection (a)(3) of this section unless the representative—

(A) has received the training required under paragraph (4); and

(B) has been approved by the Ombudsman as qualified to carry out the activity on behalf of the Office;

(6) coordinate ombudsman services with the protection and advocacy systems for individuals with developmental disabilities and mental illnesses established under—

(A) subtitle C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 [42 U.S.C. 15041 et seq.]; and

(B) the Protection and Advocacy for Mentally Ill Individuals Act of 1986³ (42 U.S.C. 10801 et seq.);

(7) coordinate, to the greatest extent possible, ombudsman services with legal assistance provided under section 3026(a)(2)(C) of this title, through adoption of memoranda of understanding and other means;

(8) coordinate services with State and local law enforcement agencies and courts of competent jurisdiction; and

(9) permit any local Ombudsman entity to carry out the responsibilities described in paragraph (1), (2), (3), (6), or (7).

(i) Liability

The State shall ensure that no representative of the Office will be liable under State law for the good faith performance of official duties.

(j) Noninterference

The State shall—

(1) ensure that willful interference with representatives of the Office in the performance of the official duties of the representatives (as defined by the Assistant Secretary) shall be unlawful;

(2) prohibit retaliation and reprisals by a long-term care facility or other entity with respect to any resident, employee, or other person for filing a complaint with, providing information to, or otherwise cooperating with any representative of, the Office; and

(3) provide for appropriate sanctions with respect to the interference, retaliation, and reprisals.

(Pub. L. 89-73, title VII, §712, as added Pub. L. 102-375, title VII, §702, Sept. 30, 1992, 106 Stat.

1276; amended Pub. L. 103-171, §3(a)(9), Dec. 2, 1993, 107 Stat. 1990; Pub. L. 106-402, title IV, §401(b)(9)(D), Oct. 30, 2000, 114 Stat. 1739; Pub. L. 106-501, title VII, §704, title VIII, §801(e)(2), Nov. 13, 2000, 114 Stat. 2289, 2293.)

REFERENCES IN TEXT

Section 3012(a)(21) of this title, referred to in subsec. (c)(2)(D), was redesignated section 3012(a)(18) of this title by Pub. L. 106-501, title II, §201(1)(B), Nov. 13, 2000, 114 Stat. 2229.

The Developmental Disabilities Assistance and Bill of Rights Act of 2000, referred to in subsec. (h)(6)(A), is Pub. L. 106-402, Oct. 30, 2000, 114 Stat. 1677. Subtitle C of the Act probably means subtitle C of title I of the Act, which is classified generally to part C (§15041 et seq.) of subchapter I of chapter 144 of this title. For complete classification of this Act to the Code, see Short Title note set out under section 15001 of this title and Tables.

The Protection and Advocacy for Mentally Ill Individuals Act of 1986, referred to in subsec. (h)(6)(B), was Pub. L. 99-319, May 23, 1986, 100 Stat. 478, as amended. Pub. L. 99-319 was renamed the Protection and Advocacy for Individuals with Mental Illness Act by Pub. L. 106-310, div. B, title XXXII, §3206(a), Oct. 17, 2000, 114 Stat. 1193, and is classified generally to chapter 114 (§10801 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 10801 of this title and Tables.

AMENDMENTS

2000—Subsec. (a)(1). Pub. L. 106-501, §801(e)(2), substituted "section 3058a of this title and made available to carry out this subpart" for "section 3058a(a) of this title" in introductory provisions.

Subsec. (a)(5)(C)(ii). Pub. L. 106-501, §704(1), inserted "and not stand to gain financially through an action or potential action brought on behalf of individuals the Ombudsman serves" after "interest".

Subsec. (h)(4). Pub. L. 106-501, §704(2)(A), substituted "strengthen and update" for "(A) not later than 1 year after September 30, 1992, establish" in introductory provisions, redesignated cls. (i) and (ii) of former subpar. (A) as subpars. (A) and (B), respectively, redesignated subcls. (I) to (III) of former subpar. (A)(ii) as cls. (i) to (iii), respectively, of subpar. (B), redesignated cl. (iii) of former subpar. (A) as subpar. (C) and struck out "and" at end, and struck out former subpar. (B) which read as follows: "require implementation of the procedures not later than 21 months after September 30, 1992;"

Subsec. (h)(6)(A). Pub. L. 106-402 substituted "subtitle C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000" for "part A of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 6001 et seq.)".

Subsec. (h)(8), (9). Pub. L. 106-501, §704(2)(B)-(D), added par. (8) and redesignated former par. (8) as (9).

1993—Subsecs. (a)(3)(I), (c)(2)(C), (h)(3)(B). Pub. L. 103-171, §3(a)(9)(B), substituted "Assistant Secretary" for "Commissioner".

Subsec. (h)(4)(A). Pub. L. 103-171, §3(a)(9)(A), substituted "Director of the Office of Long-Term Care Ombudsman Programs" for "Associate Commissioner for Ombudsman Programs".

Subsec. (j)(1). Pub. L. 103-171, §3(a)(9)(B), substituted "Assistant Secretary" for "Commissioner".

§ 3058h. Regulations

The Assistant Secretary shall issue and periodically update regulations respecting—

(1) conflicts of interest by persons described in paragraphs (1) and (2) of section 3058g(f) of this title; and

(2) the relationships described in subparagraphs (A) through (D) of section 3058g(f)(3) of this title.

³ See References in Text note below.

representative of the Office in accordance with such requirements as the State agency shall establish; or

(iii) the disclosure is required by court order.

(e) Consultation

In planning and operating the program, the State agency shall consider the views of area agencies on aging, older individuals, and providers of long-term care.

(f) Conflict of interest

The State agency shall—

(1) ensure that no individual, or member of the immediate family of an individual, involved in the designation of the Ombudsman (whether by appointment or otherwise) or the designation of an entity designated under subsection (a)(5) of this section, is subject to a conflict of interest;

(2) ensure that no officer or employee of the Office, representative of a local Ombudsman entity, or member of the immediate family of the officer, employee, or representative, is subject to a conflict of interest;

(3) ensure that the Ombudsman—

(A) does not have a direct involvement in the licensing or certification of a long-term care facility or of a provider of a long-term care service;

(B) does not have an ownership or investment interest (represented by equity, debt, or other financial relationship) in a long-term care facility or a long-term care service;

(C) is not employed by, or participating in the management of, a long-term care facility; and

(D) does not receive, or have the right to receive, directly or indirectly, remuneration (in cash or in kind) under a compensation arrangement with an owner or operator of a long-term care facility; and

(4) establish, and specify in writing, mechanisms to identify and remove conflicts of interest referred to in paragraphs (1) and (2), and to identify and eliminate the relationships described in subparagraphs (A) through (D) of paragraph (3), including such mechanisms as—

(A) the methods by which the State agency will examine individuals, and immediate family members, to identify the conflicts; and

(B) the actions that the State agency will require the individuals and such family members to take to remove such conflicts.

(g) Legal counsel

The State agency shall ensure that—

(1)(A) adequate legal counsel is available, and is able, without conflict of interest, to—

(i) provide advice and consultation needed to protect the health, safety, welfare, and rights of residents; and

(ii) assist the Ombudsman and representatives of the Office in the performance of the official duties of the Ombudsman and representatives; and

(B) legal representation is provided to any representative of the Office against whom suit

or other legal action is brought or threatened to be brought in connection with the performance of the official duties of the Ombudsman or such a representative; and

(2) the Office pursues administrative, legal, and other appropriate remedies on behalf of residents.

(h) Administration

The State agency shall require the Office to—

(1) prepare an annual report—

(A) describing the activities carried out by the Office in the year for which the report is prepared;

(B) containing and analyzing the data collected under subsection (c) of this section;

(C) evaluating the problems experienced by, and the complaints made by or on behalf of, residents;

(D) containing recommendations for—

(i) improving quality of the care and life of the residents; and

(ii) protecting the health, safety, welfare, and rights of the residents;

(E)(i) analyzing the success of the program including success in providing services to residents of board and care facilities and other similar adult care facilities; and

(ii) identifying barriers that prevent the optimal operation of the program; and

(F) providing policy, regulatory, and legislative recommendations to solve identified problems, to resolve the complaints, to improve the quality of care and life of residents, to protect the health, safety, welfare, and rights of residents, and to remove the barriers;

(2) analyze, comment on, and monitor the development and implementation of Federal, State, and local laws, regulations, and other government policies and actions that pertain to long-term care facilities and services, and to the health, safety, welfare, and rights of residents, in the State, and recommend any changes in such laws, regulations, and policies as the Office determines to be appropriate;

(3)(A) provide such information as the Office determines to be necessary to public and private agencies, legislators, and other persons, regarding—

(i) the problems and concerns of older individuals residing in long-term care facilities; and

(ii) recommendations related to the problems and concerns; and

(B) make available to the public, and submit to the Assistant Secretary, the chief executive officer of the State, the State legislature, the State agency responsible for licensing or certifying long-term care facilities, and other appropriate governmental entities, each report prepared under paragraph (1);

(4) strengthen and update procedures for the training of the representatives of the Office, including unpaid volunteers, based on model standards established by the Director of the Office of Long-Term Care Ombudsman Programs, in consultation with representatives of citizen groups, long-term care providers, and the Office, that—

protect the health, safety, welfare, and rights of the residents;

(v)(I) review, and if necessary, comment on any existing and proposed laws, regulations, and other government policies and actions, that pertain to the rights and well-being of residents; and

(II) facilitate the ability of the public to comment on the laws, regulations, policies, and actions;

(vi) support the development of resident and family councils; and

(vii) carry out other activities that the Ombudsman determines to be appropriate.

(C) Eligibility for designation

Entities eligible to be designated as local Ombudsman entities, and individuals eligible to be designated as representatives of such entities, shall—

(i) have demonstrated capability to carry out the responsibilities of the Office;

(ii) be free of conflicts of interest and not stand to gain financially through an action or potential action brought on behalf of individuals the Ombudsman serves;

(iii) in the case of the entities, be public or nonprofit private entities; and

(iv) meet such additional requirements as the Ombudsman may specify.

(D) Policies and procedures

(i) In general

The State agency shall establish, in accordance with the Office, policies and procedures for monitoring local Ombudsman entities designated to carry out the duties of the Office.

(ii) Policies

In a case in which the entities are grantees, or the representatives are employees, of area agencies on aging, the State agency shall develop the policies in consultation with the area agencies on aging. The policies shall provide for participation and comment by the agencies and for resolution of concerns with respect to case activity.

(iii) Confidentiality and disclosure

The State agency shall develop the policies and procedures in accordance with all provisions of this part regarding confidentiality and conflict of interest.

(b) Procedures for access

(1) In general

The State shall ensure that representatives of the Office shall have—

(A) access to long-term care facilities and residents;

(B)(i) appropriate access to review the medical and social records of a resident, if—

(I) the representative has the permission of the resident, or the legal representative of the resident; or

(II) the resident is unable to consent to the review and has no legal representative; or

(ii) access to the records as is necessary to investigate a complaint if—

(I) a legal guardian of the resident refuses to give the permission;

(II) a representative of the Office has reasonable cause to believe that the guardian is not acting in the best interests of the resident; and

(III) the representative obtains the approval of the Ombudsman;

(C) access to the administrative records, policies, and documents, to which the residents have, or the general public has access, of long-term care facilities; and

(D) access to and, on request, copies of all licensing and certification records maintained by the State with respect to long-term care facilities.

(2) Procedures

The State agency shall establish procedures to ensure the access described in paragraph (1).

(c) Reporting system

The State agency shall establish a statewide uniform reporting system to—

(1) collect and analyze data relating to complaints and conditions in long-term care facilities and to residents for the purpose of identifying and resolving significant problems; and

(2) submit the data, on a regular basis, to—

(A) the agency of the State responsible for licensing or certifying long-term care facilities in the State;

(B) other State and Federal entities that the Ombudsman determines to be appropriate;

(C) the Assistant Secretary; and

(D) the National Ombudsman Resource Center established in section 3012(a)(21)² of this title.

(d) Disclosure

(1) In general

The State agency shall establish procedures for the disclosure by the Ombudsman or local Ombudsman entities of files maintained by the program, including records described in subsection (b)(1) or (c) of this section.

(2) Identity of complainant or resident

The procedures described in paragraph (1) shall—

(A) provide that, subject to subparagraph (B), the files and records described in paragraph (1) may be disclosed only at the discretion of the Ombudsman (or the person designated by the Ombudsman to disclose the files and records); and

(B) prohibit the disclosure of the identity of any complainant or resident with respect to whom the Office maintains such files or records unless—

(i) the complainant or resident, or the legal representative of the complainant or resident, consents to the disclosure and the consent is given in writing;

(ii)(I) the complainant or resident gives consent orally; and

(II) the consent is documented contemporaneously in a writing made by a rep-

²See References in Text note below.

§ 3058g. State Long-Term Care Ombudsman program

(a) Establishment

(1) In general

In order to be eligible to receive an allotment under section 3058b of this title from funds appropriated under section 3058a of this title and made available to carry out this subpart, a State agency shall, in accordance with this section—

(A) establish and operate an Office of the State Long-Term Care Ombudsman; and

(B) carry out through the Office a State Long-Term Care Ombudsman program.

(2) Ombudsman

The Office shall be headed by an individual, to be known as the State Long-Term Care Ombudsman, who shall be selected from among individuals with expertise and experience in the fields of long-term care and advocacy.

(3) Functions

The Ombudsman shall serve on a full-time basis, and shall, personally or through representatives of the Office—

(A) identify, investigate, and resolve complaints that—

(i) are made by, or on behalf of, residents; and

(ii) relate to action, inaction, or decisions, that may adversely affect the health, safety, welfare, or rights of the residents (including the welfare and rights of the residents with respect to the appointment and activities of guardians and representative payees), of—

(I) providers, or representatives of providers, of long-term care services;

(II) public agencies; or

(III) health and social service agencies;

(B) provide services to assist the residents in protecting the health, safety, welfare, and rights of the residents;

(C) inform the residents about means of obtaining services provided by providers or agencies described in subparagraph (A)(ii) or services described in subparagraph (B);

(D) ensure that the residents have regular and timely access to the services provided through the Office and that the residents and complainants receive timely responses from representatives of the Office to complaints;

(E) represent the interests of the residents before governmental agencies and seek administrative, legal, and other remedies to protect the health, safety, welfare, and rights of the residents;

(F) provide administrative and technical assistance to entities designated under paragraph (5) to assist the entities in participating in the program;

(G)(i) analyze, comment on, and monitor the development and implementation of Federal, State, and local laws, regulations, and other governmental policies and actions, that pertain to the health, safety, welfare, and rights of the residents, with respect to the adequacy of long-term care facilities and services in the State;

(ii) recommend any changes in such laws, regulations, policies, and actions as the Office determines to be appropriate; and

(iii) facilitate public comment on the laws, regulations, policies, and actions;

(H)(i) provide for training representatives of the Office;

(ii) promote the development of citizen organizations, to participate in the program; and

(iii) provide technical support for the development of resident and family councils to protect the well-being and rights of residents; and

(I) carry out such other activities as the Assistant Secretary determines to be appropriate.

(4) Contracts and arrangements

(A) In general

Except as provided in subparagraph (B), the State agency may establish and operate the Office, and carry out the program, directly, or by contract or other arrangement with any public agency or nonprofit private organization.

(B) Licensing and certification organizations; associations

The State agency may not enter into the contract or other arrangement described in subparagraph (A) with—

(i) an agency or organization that is responsible for licensing or certifying long-term care services in the State; or

(ii) an association (or an affiliate of such an association) of long-term care facilities, or of any other residential facilities for older individuals.

(5) Designation of local Ombudsman entities and representatives

(A) Designation

In carrying out the duties of the Office, the Ombudsman may designate an entity as a local Ombudsman entity, and may designate an employee or volunteer to represent the entity.

(B) Duties

An individual so designated shall, in accordance with the policies and procedures established by the Office and the State agency—

(i) provide services to protect the health, safety, welfare¹ and rights of residents;

(ii) ensure that residents in the service area of the entity have regular, timely access to representatives of the program and timely responses to complaints and requests for assistance;

(iii) identify, investigate, and resolve complaints made by or on behalf of residents that relate to action, inaction, or decisions, that may adversely affect the health, safety, welfare, or rights of the residents;

(iv) represent the interests of residents before government agencies and seek administrative, legal, and other remedies to

¹ So in original. Probably should be followed by a comma.

Attachment F2:
Nursing Home Reform Act

TITLE 42 -- PUBLIC HEALTH
CHAPTER IV -- CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH
AND HUMAN SERVICES
SUBCHAPTER G -- STANDARDS AND CERTIFICATION
PART 483 -- REQUIREMENTS FOR STATES AND LONG TERM CARE FACILITIES
SUBPART B -- REQUIREMENTS FOR LONG TERM CARE FACILITIES

§ 483.1 Basis and scope.

- (a) Statutory basis. (1) Sections 1819 (a), (b), (c), and (d) of the Act provide that --
- (i) Skilled nursing facilities participating in Medicare must meet certain specified requirements; and
- (ii) The Secretary may impose additional requirements (see section 1819(d)(4)(B)) if they are necessary for the health and safety of individuals to whom services are furnished in the facilities.
- (2) Section 1861(l) of the Act requires the facility to have in effect a transfer agreement with a hospital.
- (3) Sections 1919 (a), (b), (c), and (d) of the Act provide that nursing facilities participating in Medicaid must meet certain specific requirements.
- (b) Scope. The provisions of this part contain the requirements that an institution must meet in order to qualify to participate as a SNF in the Medicare program, and as a nursing facility in the Medicaid program. They serve as the basis for survey activities for the purpose of determining whether a facility meets the requirements for participation in Medicare and Medicaid.

HISTORY:

[56 FR 48867, Sept. 26, 1991, as amended at 57 FR 43924, Sept. 23, 1992; 60 FR 50439, 50443, Sept. 29, 1995]

§ 483.5 Definitions.

(a) Facility defined. For purposes of this subpart, facility means a skilled nursing facility (SNF) that meets the requirements of sections 1819(a), (b), (c), and (d) of the Act, or a nursing facility (NF) that meets the requirements of sections 1919(a), (b), (c), and (d) of the Act. "Facility" may include a distinct part of an institution (as defined in paragraph (b) of this section and specified in § 440.40 and § 440.155 of this chapter), but does not include an institution for the mentally retarded or persons with related conditions described in § 440.150 of this chapter. For Medicare and Medicaid purposes (including eligibility, coverage, certification, and payment), the "facility" is always the entity that participates in the program, whether that entity is comprised of all of, or a distinct part of, a larger institution. For Medicare, an SNF (see section 1819(a)(1) of the Act), and for Medicaid, an NF (see section 1919(a)(1) of the Act) may not be an institution for mental diseases as defined in § 435.1009 of this chapter.

(b) Distinct part -- (1) Definition. A distinct part SNF or NF is physically distinguishable from the larger institution or institutional complex that houses it, meets the requirements of this paragraph and of paragraph (b)(2) of this section, and meets the applicable statutory requirements for SNFs or NFs in sections 1819 or 1919 of the Act, respectively. A distinct part SNF or NF may be comprised of one or more buildings or designated parts of buildings (that is, wings, wards, or floors) that are: In the same physical area immediately adjacent to the institution's main buildings; other areas and structures that are not strictly contiguous to the main buildings but are located within close proximity of the main buildings; and any other areas that CMS determines on an individual basis, to be part of the institution's campus. A distinct part must include all of the beds within the designated area, and cannot consist of a random collection of individual rooms or beds that are scattered throughout the physical plant. The term "distinct part" also includes a composite distinct part that meets the additional requirements of paragraph (c) of this section.

(2) Requirements. In addition to meeting the participation requirements for long-term care facilities set forth elsewhere in this subpart, a distinct part SNF or NF must meet all of the following requirements:

(i) The SNF or NF must be operated under common ownership and control (that is, common governance) by the institution of which it is a distinct part, as evidenced by the following:

(A) The SNF or NF is wholly owned by the institution of which it is a distinct part.

(B) The SNF or NF is subject to the by-laws and operating decisions of a common governing body.

(C) The institution of which the SNF or NF is a distinct part has final responsibility for the distinct part's administrative decisions and personnel policies, and final approval for the distinct part's personnel actions.

(D) The SNF or NF functions as an integral and subordinate part of the institution of which it is a distinct part, with significant common resource usage of buildings, equipment, personnel, and services.

(ii) The administrator of the SNF or NF reports to and is directly accountable to the management of the institution of which the SNF or NF is a distinct part.

(iii) The SNF or NF must have a designated medical director who is responsible for implementing care policies and coordinating medical care, and who is directly accountable to the management of the institution of which it is a distinct part.

(iv) The SNF or NF is financially integrated with the institution of which it is a distinct part, as evidenced by the sharing of income and expenses with that institution, and the reporting of its costs on that institution's cost report.

(v) A single institution can have a maximum of only one distinct part SNF and one distinct part NF.

(vi) (A) An institution cannot designate a distinct part SNF or NF, but instead must submit a written request with documentation that demonstrates it meets the criteria set forth above to CMS to determine if it may be considered a distinct part.

(B) The effective date of approval of a distinct part is the date that CMS determines all requirements (including enrollment with the fiscal intermediary (FI)) are met for approval, and cannot be made retroactive.

(C) The institution must request approval from CMS for all proposed changes in the number of beds in the approved distinct part.

(c) Composite distinct part – (1) Definition. A composite distinct part is a distinct part consisting of two or more noncontiguous components that are not located within the same campus, as defined in § 413.65(a)(2) of this chapter.

(2) Requirements. In addition to meeting the requirements of paragraph (b) of this section, a composite distinct part must meet all of the following requirements:

(i) A SNF or NF that is a composite of more than one location will be treated as a single distinct part of the institution of which it is a distinct part. As such, the composite distinct part will have only one provider agreement and only one provider number.

(ii) If two or more institutions (each with a distinct part SNF or NF) undergo a change of ownership, CMS must approve the existing SNFs or NFs as meeting the requirements before they are considered a composite distinct part of a single institution. In making such a determination, CMS considers whether its approval or disapproval of a composite distinct part promotes the effective and efficient use of public monies without sacrificing the quality of care.

(iii) If there is a change of ownership of a composite distinct part SNF or NF, the assignment of the provider agreement to the new owner will apply to all of the approved locations that comprise the composite distinct part SNF or NF.

(iv) To ensure quality of care and quality of life for all residents, the various components of a composite distinct part must meet all of the requirements for participation independently in each location.

HISTORY:

[56 FR 48867, Sept. 26, 1991, as amended at 57 FR 43924, Sept. 23, 1992; 68 FR 46036, 46071, Aug. 4, 2003]

§ 483.10 Resident rights.

The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident, including each of the following rights:

(a) Exercise of rights.

(1) The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights.

(3) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under State law to act on the resident's behalf.

(4) In the case of a resident who has not been adjudged incompetent by the State court, any legal-surrogate designated in accordance with State law may exercise the resident's rights to the extent provided by State law.

(b) Notice of rights and services. (1) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under section 1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing;

(2) The resident or his or her legal representative has the right --

(i) Upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays); and

(ii) After receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and 2 working days advance notice to the facility.

(3) The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition;

(4) The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section; and

(5) The facility must --

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

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

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

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

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

(7) The facility must furnish a written description of legal rights that includes --

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

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

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

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

(8) The facility must comply with the requirements specified in subpart I of part 489 of this chapter relating to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. If an adult individual is incapacitated at the time of admission and is unable to receive information (due to the incapacitating condition or a mental disorder) or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated individual or to a surrogate or other concerned persons in accordance with State law. The facility is not relieved of its obligation to provide this information to the individual once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.

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

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

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

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

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

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

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

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

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

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

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

(12) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in § 483.5(c) of this subpart) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under § 483.12(a)(8).

(c) Protection of Resident Funds. (1) The resident has the right to manage his or her financial affairs, and the facility may not require residents to deposit their personal funds with the facility.

(2) Management of personal funds. Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.

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

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

(4) Accounting and records. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

(i) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

(ii) The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.

(5) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits --

(i) When the amount in the resident's account reaches \$ 200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and

(ii) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

(6) Conveyance upon death. Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.

(7) Assurance of financial security. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.

(8) Limitation on charges to personal funds. The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts). The facility may charge the resident for requested services that are more expensive than or in excess of covered services in accordance with § 489.32 of this chapter. (This does not affect the prohibition on facility charges for items and services for which Medicaid has paid. See § 447.15, which limits participation in the Medicaid program to providers who accept, as payment in full, Medicaid payment plus any deductible, coinsurance, or copayment required by the plan to be paid by the individual.)

(i) Services included in Medicare or Medicaid payment. During the course of a covered Medicare or Medicaid stay, facilities may not charge a resident for the following categories of items and services:

(A) Nursing services as required at § 483.30 of this subpart.

(B) Dietary services as required at § 483.35 of this subpart.

(C) An activities program as required at § 483.15(f) of this subpart.

(D) Room/bed maintenance services.

(E) Routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing, and basic personal laundry.

(F) Medically-related social services as required at § 483.15(g) of this subpart.

(ii) Items and services that may be charged to residents' funds. Listed below are general categories and examples of items and services that the facility may charge to residents' funds if they are requested by a resident, if the facility informs the resident that there will be a charge, and if payment is not made by Medicare or Medicaid:

(A) Telephone.

(B) Television/radio for personal use.

(C) Personal comfort items, including smoking materials, notions and novelties, and confections.

(D) Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare.

(E) Personal clothing.

(F) Personal reading matter.

(G) Gifts purchased on behalf of a resident.

(H) Flowers and plants.

(I) Social events and entertainment offered outside the scope of the activities program, provided under § 483.15(f) of this subpart.

(J) Noncovered special care services such as privately hired nurses or aides.

(K) Private room, except when therapeutically required (for example, isolation for infection control).

(L) Specially prepared or alternative food requested instead of the food generally prepared by the facility, as required by § 483.35 of this subpart.

(iii) Requests for items and services. (A) The facility must not charge a resident (or his or her representative) for any item or service not requested by the resident.

(B) The facility must not require a resident (or his or her representative) to request any item or service as a condition of admission or continued stay.

(C) The facility must inform the resident (or his or her representative) requesting an item or service for which a charge will be made that there will be a charge for the item or service and what the charge will be.

(d) Free choice. The resident has the right to --

(1) Choose a personal attending physician;

(2) Be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being; and

(3) Unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, participate in planning care and treatment or changes in care and treatment.

(e) Privacy and confidentiality. The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.

(1) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident;

(2) Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility;

(3) The resident's right to refuse release of personal and clinical records does not apply when --

(i) The resident is transferred to another health care institution; or

(ii) Record release is required by law.

(f) Grievances. A resident has the right to --

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

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

(g) Examination of survey results. A resident has the right to --

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

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

(h) Work. The resident has the right to --

(1) Refuse to perform services for the facility;

(2) Perform services for the facility, if he or she chooses, when --

(i) The facility has documented the need or desire for work in the plan of care;

(ii) The plan specifies the nature of the services performed and whether the services are voluntary or paid;

(iii) Compensation for paid services is at or above prevailing rates; and

(iv) The resident agrees to the work arrangement described in the plan of care.

(i) Mail. The resident has the right to privacy in written communications, including the right to --

(1) Send and promptly receive mail that is unopened; and

(2) Have access to stationery, postage, and writing implements at the resident's own expense.

(j) Access and visitation rights. (1) The resident has the right and the facility must provide immediate access to any resident by the following:

(i) Any representative of the Secretary;

(ii) Any representative of the State;

(iii) The resident's individual physician;

(iv) The State long term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965);

(v) The agency responsible for the protection and advocacy system for developmentally disabled individuals (established under part C of the Developmental Disabilities Assistance and Bill of Rights Act);

(vi) The agency responsible for the protection and advocacy system for mentally ill individuals (established under the Protection and Advocacy for Mentally Ill Individuals Act);

(vii) Subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident; and

(viii) Subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, others who are visiting with the consent of the resident.

(2) The facility must provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.

(3) The facility must allow representatives of the State Ombudsman, described in paragraph (j)(1)(iv) of this section, to examine a resident's clinical records with the permission of the resident or the resident's legal representative, and consistent with State law.

(k) Telephone. The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard.

(l) 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.

(m) Married couples. The resident has the right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement.

(n) Self-Administration of Drugs. An individual resident may self-administer drugs if the interdisciplinary team, as defined by § 483.20(d)(2)(ii), has determined that this practice is safe.

(o) Refusal of certain transfers. (1) An individual has the right to refuse a transfer to another room within the institution, if the purpose of the transfer is to relocate --

(i) A resident of a SNF from the distinct part of the institution that is a SNF to a part of the institution that is not a SNF, or

(ii) A resident of a NF from the distinct part of the institution that is a NF to a distinct part of the institution that is a SNF.

(2) A resident's exercise of the right to refuse transfer under paragraph (o)(1) of this section does not affect the individual's eligibility or entitlement to Medicare or Medicaid benefits.

HISTORY:

[56 FR 48867, Sept. 26, 1991, as amended at 57 FR 8202, Mar. 6, 1992; 57 FR 43924, Sept. 23, 1992; 57 FR 53587, Nov. 12, 1992; 60 FR 33293, June 27, 1995; 68 FR 46036, 46072, Aug. 4, 2003]

NOTES:

[EFFECTIVE DATE NOTE: 68 FR 46036, 46072, Aug. 4, 2003, added paragraph (b)(12), effective Oct. 1, 2003.]

§ 483.12 Admission, transfer and discharge rights.

(a) Transfer and discharge --

(1) Definition: Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.

(2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless --

(i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;

(ii) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

(iii) The safety of individuals in the facility is endangered;

(iv) The health of individuals in the facility would otherwise be endangered;

(v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or

(vi) The facility ceases to operate.

(3) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by --

(i) The resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and

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

(4) Notice before transfer. Before a facility transfers or discharges a resident, the facility must --

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

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

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

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

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

(A) the safety of individuals in the facility would be endangered under paragraph (a)(2)(iii) of this section;

(B) The health of individuals in the facility would be endangered, under paragraph (a)(2)(iv) of this section;

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

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

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

(6) Contents of the notice. The written notice specified in paragraph (a)(4) of this section must include the following:

(i) The reason for transfer or discharge;

(ii) The effective date of transfer or discharge;

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

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

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

(vi) For nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and

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

(7) Orientation for transfer or discharge. A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

(8) Room changes in a composite distinct part. Room changes in a facility that is a composite distinct part (as defined in § 483.5(c)) must be limited to moves within the particular building in which the resident resides, unless the resident voluntarily agrees to move to another of the composite distinct part's locations.

(b) Notice of bed-hold policy and readmission -- (1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies --

(i) The duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility; and

(ii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return.

(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.

(3) Permitting resident to return to facility. A nursing facility must establish and follow a written policy under which a resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, is readmitted to the facility immediately upon the first availability of a bed in a semi-private room if the resident --

(i) Requires the services provided by the facility; and

(ii) Is eligible for Medicaid nursing facility services.

(4) Readmission to a composite distinct part. When the nursing facility to which a resident is readmitted is a composite distinct part (as defined in § 483.5(c) of this subpart), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of readmission, the resident must be given the option to return to that location upon the first availability of a bed there.

(c) Equal access to quality care.

(1) A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all individuals regardless of source of payment;

(2) The facility may charge any amount for services furnished to non-Medicaid residents consistent with the notice requirement in § 483.10(b)(5)(i) and (b)(6) describing the charges; and

(3) The State is not required to offer additional services on behalf of a resident other than services provided in the State plan.

(d) Admissions policy.

(1) The facility must --

(i) Not require residents or potential residents to waive their rights to Medicare or Medicaid; and

(ii) Not require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits.

(2) The facility must not require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may require an individual who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources.

(3) In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility. However, --

(i) A nursing facility may charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the State plan as included in the term "nursing facility services" so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident's admission or continued stay on the request for and receipt of such additional services; and

(ii) A nursing facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility for a Medicaid eligible resident.

(4) States or political subdivisions may apply stricter admissions standards under State or local laws than are specified in this section, to prohibit discrimination against individuals entitled to Medicaid.

HISTORY:

[56 FR 48869, Sept. 26, 1991, as amended at 57 FR 43924, Sept. 23, 1992; 68 FR 46036, 46072, Aug. 4, 2003]

NOTES:

[EFFECTIVE DATE NOTE: 68 FR 46036, 46072, Aug. 4, 2003, added paragraphs (a)(8) and (b)(4), effective Oct. 1, 2003.]

§ 483.13 Resident behavior and facility practices.

(a) **Restraints.** The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

(b) **Abuse.** The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.

(c) **Staff treatment of residents.** The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

(1) The facility must—

- (i) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;
 - (ii) Not employ individuals who have been—
 - (A) Found guilty of abusing, neglecting, or mistreating residents by a court of law; or
 - (B) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and
 - (iii) Report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.
- (2) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).
- (3) The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.
- (4) The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

HISTORY:

[56 FR 48870, Sept. 26, 1991, as amended at 57 FR 43924, Sept. 23, 1992]

§ 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.

(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.

(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.

(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;

(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.

(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.

(e) Accommodation of needs. A resident has the right to--

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

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

(f) Activities. (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.

(2) The activities program must be directed by a qualified professional who--

(i) Is a qualified therapeutic recreation specialist or an activities professional who--

(A) Is licensed or registered, if applicable, by the State in which practicing; and

(B) Is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or

(ii) Has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or

(iii) Is a qualified occupational therapist or occupational therapy assistant; or

(iv) Has completed a training course approved by the State.

(g) Social Services. (1)--The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

(2) A facility with more than 120 beds must employ a qualified social worker on a full-time basis.

(3) Qualifications of social worker. A qualified social worker is an individual with--

(i) A bachelor's degree in social work or a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling, and psychology; and

(ii) One year of supervised social work experience in a health care setting working directly with individuals.

(h) Environment.

The facility must provide--

(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal

belongings to the extent possible;

(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

(3) Clean bed and bath linens that are in good condition;

(4) Private closet space in each resident room, as specified in § 483.70(d)(2)(iv) of this part;

(5) Adequate and comfortable lighting levels in all areas;

(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71-81[degrees]F; and

(7) For the maintenance of comfortable sound levels.

HISTORY:

[56 FR 48871, Sept. 26, 1991, as amended at 57 FR 43924, Sept. 23, 1992]

§ 483.20 Resident assessment.

The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity.

(a) Admission orders. At the time each resident is admitted, the facility must have physician orders for the resident's immediate care.

(b) Comprehensive assessments.

(1) Resident assessment instrument. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:

(i) Identification and demographic information.

(ii) Customary routine.

(iii) Cognitive patterns.

(iv) Communication.

(v) Vision.

(vi) Mood and behavior patterns.

(vii) Psychosocial well-being.

(viii) Physical functioning and structural problems.

(ix) Continence.

(x) Disease diagnoses and health conditions.

(xi) Dental and nutritional status.

(xii) Skin condition.

(xiii) Activity pursuit.

(xiv) Medications.

(xv) Special treatments and procedures.

(xvi) Discharge potential.

(xvii) Documentation of summary information regarding the additional assessment performed through the resident assessment protocols.

(xviii) Documentation of participation in assessment.

The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

(2) When required. Subject to the timeframes prescribed in § 413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2) (i) through (iii) of this section. The timeframes prescribed in § 413.343(b) of this chapter do not apply to CAHs.

(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.)

(ii) Within 14 calendar days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purposes of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)

(iii) Not less often than once every 12 months.

(c) Quarterly review assessment. A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.

(d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review, and revise the resident's comprehensive plan of care.

(e) Coordination. A facility must coordinate assessments with the preadmission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort.

(f) Automated data processing requirement. (1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:

(i) Admission assessment.

(ii) Annual assessment updates.

(iii) Significant change in status assessments.

(iv) Quarterly review assessments.

(v) A subset of items upon a resident's transfer, reentry, discharge, and death.

(vi) Background (face-sheet) information, if there is no admission assessment.

(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the State information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

(3) Monthly transmittal requirements. A facility must electronically transmit, at least monthly, encoded, accurate, complete MDS data to the State for all assessments conducted during the previous month, including the following:

(i) Admission assessment.

(ii) Annual assessment.

(iii) Significant change in status assessment.

(iv) Significant correction of prior full assessment.

(v) Significant correction of prior quarterly assessment.

(vi) Quarterly review.

(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.

(viii) Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment.

(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.

(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public.

(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

(g) Accuracy of assessments. The assessment must accurately reflect the resident's status.

(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

(i) Certification. (1) A registered nurse must sign and certify that the assessment is completed.

(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

(j) Penalty for falsification. (1) Under Medicare and Medicaid, an individual who willfully and knowingly --

(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$ 1,000 for each assessment; or

(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$ 5,000 for each assessment.

(2) Clinical disagreement does not constitute a material and false statement.

(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).

(2) A comprehensive care plan must be --

(i) Developed within 7 days after completion of the comprehensive assessment;

(ii) Prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and

(iii) Periodically reviewed and revised by a team of qualified persons after each assessment.

(3) The services provided or arranged by the facility must --

(i) Meet professional standards of quality; and

(ii) Be provided by qualified persons in accordance with each resident's written plan of care.

(l) Discharge summary. When the facility anticipates discharge a resident must have a discharge summary that includes --

(1) A recapitulation of the resident's stay;

(2) A final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative; and

(3) A post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.

(m) Preadmission screening for mentally ill individuals and individuals with mental retardation. (1) A nursing facility must not admit, on or after January 1, 1989, any new resident with --

(i) Mental illness as defined in paragraph (f)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,

(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and

(B) If the individual requires such level of services, whether the individual requires specialized services; or

(ii) Mental retardation, as defined in paragraph (f)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission --

(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and

(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.

(2) Definition. For purposes of this section--

(i) An individual is considered to have mental illness if the individual has a serious mental illness as defined in § 483.102(b)(1).

(ii) An individual is considered to be mentally retarded if the individual is mentally retarded as defined in § 483.102(b)(3) or is a person with a related condition as described in 42 CFR 435.1009.

HISTORY:

[56 FR 48871, Sept. 26, 1991, as amended at 57 FR 43924, Sept. 23, 1992; 62 FR 67174, 67211, Dec. 23, 1997; 63 FR 26252, 26311, May 12, 1998, as corrected at 63 FR 53301, 53307, Oct. 5, 1998; 64 FR 41490, 41543, July 30, 1999; 68 FR 46036, 46072, Aug. 4, 2003]

NOTES:

[EFFECTIVE DATE NOTE: 68 FR 46036, 46072, Aug. 4, 2003, amended paragraph (k)(1), effective Oct. 1, 2003.]

§ 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.

(a) Activities of daily living. Based on the comprehensive assessment of a resident, the facility must ensure that--

(1) A resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to--

(i) Bathe, dress, and groom;

(ii) Transfer and ambulate;

(iii) Toilet;

(iv) Eat; and

(v) Use speech, language, or other functional communication systems.

(2) A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section; and

(3) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

(b) Vision and hearing. To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident--

(1) In making appointments, and

(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.

(c) Pressure sores. Based on the comprehensive assessment of a resident, the facility must ensure that--

(1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and

(2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

(d) Urinary Incontinence. Based on the resident's comprehensive assessment, the facility must ensure that--

(1) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and

(2) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

(e) Range of motion. Based on the comprehensive assessment of a resident, the facility must ensure that--

(1) A resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and

(2) A resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

(f) Mental and Psychosocial functioning. Based on the comprehensive assessment of a resident, the facility must ensure that--

(1) A resident who displays mental or psychosocial adjustment difficulty, receives appropriate treatment and services to correct the assessed problem, and

(2) A resident whose assessment did not reveal a mental or psychosocial adjustment difficulty does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that such a pattern was unavoidable.

(g) Naso-gastric tubes. Based on the comprehensive assessment of a resident, the facility must ensure that--

(1) A resident who has been able to eat enough alone or with assistance is not fed by naso-gastric tube unless the resident's clinical condition demonstrates that use of a naso-gastric tube was unavoidable; and

(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.

(h) Accidents. The facility must ensure that--

(1) The resident environment remains as free of accident hazards as is possible; and

(2) Each resident receives adequate supervision and assistance devices to prevent accidents.

(i) Nutrition. Based on a resident's comprehensive assessment, the facility must ensure that a resident--

(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and

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

(j) Hydration. The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.

(k) Special needs. The facility must ensure that residents receive proper treatment and care for the following special services:

(1) Injections;

(2) Parenteral and enteral fluids;

(3) Colostomy, ureterostomy, or ileostomy care;

(4) Tracheostomy care;

(5) Tracheal suctioning;

(6) Respiratory care;

(7) Foot care; and

(8) Prostheses.

(l) Unnecessary drugs—(1) General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:

(i) In excessive dose (including duplicate drug therapy); or

(ii) For excessive duration; or

(iii) Without adequate monitoring; or

(iv) Without adequate indications for its use; or

(v) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or

(vi) Any combinations of the reasons above.

(2) Antipsychotic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that--

(i) Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and

(ii) Residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

(m) Medication Errors--The facility must ensure that--

(1) It is free of medication error rates of five percent or greater; and

(2) Residents are free of any significant medication errors.

HISTORY:

[56 FR 48873, Sept. 26, 1991, as amended at 57 FR 43925, Sept. 23, 1992]

§ 483.30 Nursing services.

The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

(a) Sufficient staff. (1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

(i) Except when waived under paragraph (c) of this section, licensed nurses; and

(ii) Other nursing personnel.

(2) Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

(b) Registered nurse. (1) Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.

(2) Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.

(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.

(c) Nursing facilities: Waiver of requirement to provide licensed nurses on a 24-hour basis. To the extent that a facility is unable to meet the requirements of paragraphs (a)(2) and (b)(1) of this section, a State may waive such requirements with respect to the facility if--

(1) The facility demonstrates to the satisfaction of the State that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities), to recruit appropriate personnel;

(2) The State determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility;

(3) The State finds that, for any periods in which licensed nursing services are not available, a registered nurse or a physician is obligated to respond immediately to telephone calls from the facility;

(4) A waiver granted under the conditions listed in paragraph (c) of this section is subject to annual State review;

(5) In granting or renewing a waiver, a facility may be required by the State to use other qualified, licensed personnel;

(6) The State agency granting a waiver of such requirements provides notice of the waiver to the State long term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965) and the protection and advocacy system in the State for the mentally ill and mentally retarded; and

(7) The nursing facility that is granted such a waiver by a State notifies residents of the facility (or, where appropriate, the guardians or legal representatives of such residents) and members of their immediate families

of the waiver.

(d) SNFs: Waiver of the requirement to provide services of a registered nurse for more than 40 hours a week.

(1) The Secretary may waive the requirement that a SNF provide the services of a registered nurse for more than 40 hours a week, including a director of nursing specified in paragraph (b) of this section, if the Secretary finds that--

(i) The facility is located in a rural area and the supply of skilled nursing facility services in the area is not sufficient to meet the needs of individuals residing in the area;

(ii) The facility has one full-time registered nurse who is regularly on duty at the facility 40 hours a week; and

(iii) The facility either--

(A) Has only patients whose physicians have indicated (through physicians' orders or admission notes) that they do not require the services of a registered nurse or a physician for a 48-hours period, or

(B) Has made arrangements for a registered nurse or a physician to spend time at the facility, as determined necessary by the physician, to provide necessary skilled nursing services on days when the regular full-time registered nurse is not on duty;

(iv) The Secretary provides notice of the waiver to the State long term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965) and the protection and advocacy system in the State for the mentally ill and mentally retarded; and

(v) The facility that is granted such a waiver notifies residents of the facility (or, where appropriate, the guardians or legal representatives of such residents) and members of their immediate families of the waiver.

(2) A waiver of the registered nurse requirement under paragraph (d)(1) of this section is subject to annual renewal by the Secretary.

HISTORY:

[56 FR 48873, Sept. 26, 1991, as amended at 57 FR 43925, Sept. 23, 1992]

§ 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.

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

(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.

(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.

(b) Sufficient staff. The facility must employ sufficient support personnel competent to carry out the functions of the dietary service.

(c) Menus and nutritional adequacy. Menus must --

(1) Meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food

and Nutrition Board of the National Research Council, National Academy of Sciences;

(2) Be prepared in advance; and

(3) Be followed.

(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;

(3) Food prepared in a form designed to meet individual needs; and

(4) Substitutes offered of similar nutritive value to residents who refuse food served.

(e) Therapeutic diets. Therapeutic diets must be prescribed by the attending physician.

(f) Frequency of meals. (1) Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.

(2) There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided in (4) below.

(3) The facility must offer snacks at bedtime daily.

(4) When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.

(g) Assistive devices. The facility must provide special eating equipment and utensils for residents who need them.

(h) Paid feeding assistants -- (1) State-approved training course. A facility may use a paid feeding assistant, as defined in § 488.301 of this chapter, if --

(i) The feeding assistant has successfully completed a State-approved training course that meets the requirements of § 483.160 before feeding residents; and

(ii) The use of feeding assistants is consistent with State law.

(2) Supervision. (i) A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN).

(ii) In an emergency, a feeding assistant must call a supervisory nurse for help on the resident call system.

(3) Resident selection criteria.

(i) A facility must ensure that a feeding assistant feeds only residents who have no complicated feeding problems.

(ii) Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings.

(iii) The facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care.

(i) Sanitary conditions. The facility must --

- (1) Procure food from sources approved or considered satisfactory by Federal, State, or local authorities;
- (2) Store, prepare, distribute, and serve food under sanitary conditions; and
- (3) Dispose of garbage and refuse properly.

HISTORY:

[56 FR 48874, Sept. 26, 1991; 68 FR 55528, 55539, Sept. 26, 2003]

NOTES:

[EFFECTIVE DATE NOTE: 68 FR 55528, 55539, Sept. 26, 2003, amended this section, effective Oct. 27, 2003.]

§ 483.40 Physician services.

A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician.

(a) Physician supervision. The facility must ensure that --

- (1) The medical care of each resident is supervised by a physician; and
- (2) Another physician supervises the medical care of residents when their attending physician is unavailable.

(b) Physician visits. The physician must --

- (1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section;
- (2) Write, sign, and date progress notes at each visit; and
- (3) Sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.

(c) Frequency of physician visits.

- (1) The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.
- (2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.
- (3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally.
- (4) At the option of the physician, required visits in SNFs after the initial visit may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner, or clinical nurse specialist in accordance with paragraph (e) of this section.

(d) Availability of physicians for emergency care. The facility must provide or arrange for the provision of physician services 24 hours a day, in case of an emergency.

(e) Physician delegation of tasks in SNFs. (1) Except as specified in paragraph (c)(2) of this section, a physician

may delegate tasks to a physician assistant, nurse practitioner, or clinical nurse specialist who—

(i) Meets the applicable definition in § 491.2 of this chapter or, in the case of a clinical nurse specialist, is licensed as such by the State;

(ii) Is acting within the scope of practice as defined by State law; and

(iii) Is under the supervision of the physician.

(2) A physician may not delegate a task when the regulations specify that the physician must perform it personally, or when the delegation is prohibited under State law or by the facility's own policies.

(f) Performance of physician tasks in NFs. At the option of the State, any required physician task in a NF (including tasks which the regulations specify must be performed personally by the physician) may also be satisfied when performed by a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility but who is working in collaboration with a physician.

HISTORY:

[56 FR 48875, Sept. 26, 1991; 67 FR 61808, 61814, Oct. 2, 2002]

NOTES:

[EFFECTIVE DATE NOTE: 67 FR 61808, 61814, Oct. 2, 2002, revised paragraph (b)(3), effective Oct. 2, 2002.]

§ 483.45 Specialized rehabilitative services.

(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must--

(1) Provide the required services; or

(2) Obtain the required services from an outside resource (in accordance with § 483.75(h) of this part) from a provider of specialized rehabilitative services.

(b) Qualifications. Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel.

HISTORY:

[56 FR 48875, Sept. 26, 1991, as amended at 57 FR 43925, Sept. 23, 1992]

§ 483.55 Dental services.

The facility must assist residents in obtaining routine and 24-hour emergency dental care.

(a) Skilled nursing facilities. A facility (1) Must provide or obtain from an outside resource, in accordance with § 483.75(h) of this part, routine and emergency dental services to meet the needs of each resident;

(2) May charge a Medicare resident an additional amount for routine and emergency dental services;

(3) Must if necessary, assist the resident--

(i) In making appointments; and

(ii) By arranging for transportation to and from the dentist's office; and

(4) Promptly refer residents with lost or damaged dentures to a dentist.

(b) Nursing facilities. The facility (1) Must provide or obtain from an outside resource, in accordance with § 483.75(h) of this part, the following dental services to meet the needs of each resident:

(i) Routine dental services (to the extent covered under the State plan); and

(ii) Emergency dental services;

(2) Must, if necessary, assist the resident--

(i) In making appointments; and

(ii) By arranging for transportation to and from the dentist's office; and

(3) Must promptly refer residents with lost or damaged dentures to a dentist.

HISTORY:

[56 FR 48875, Sept. 26, 1991]

§ 483.60 Pharmacy services.

The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in § 483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

(b) Service consultation. The facility must employ or obtain the services of a licensed pharmacist who--

(1) Provides consultation on all aspects of the provision of pharmacy services in the facility;

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(c) Drug regimen review. (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

(2) The pharmacist must report any irregularities to the attending physician and the director of nursing, and these reports must be acted upon.

(d) Labeling of drugs and biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

(e) Storage of drugs and biologicals.

(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked

compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

HISTORY:

[56 FR 48875, Sept. 26, 1991, as amended at 57 FR 43925, Sept. 23, 1992]

§ 483.65 Infection control.

The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection control program. The facility must establish an infection control program under which it--

(1) Investigates, controls, and prevents infections in the facility;

(2) Decides what procedures, such as isolation, should be applied to an individual resident; and

(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing spread of infection. (1) When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.

(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.

(3) The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice.

(c) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

HISTORY:

[56 FR 48876, Sept. 26, 1991, as amended at 57 FR 43925, Sept. 23, 1992]

§ 483.70 Physical environment.

The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public.

(a) Life safety from fire. Except as otherwise provided in this section, the facility must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101 [registered trademark] 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD and at the Office of the Federal Register, 800 North Capitol Street NW., Suite 700, Washington, DC. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes. Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the LSC does not apply to long-term care facilities.

(1) A facility is considered to be in compliance with this requirement as long as the facility --

(i) On November 26, 1982, complied with or without waivers, with the requirements of the 1967 or 1973 editions of the Life Safety Code and continues to remain in compliance with those editions of the Code; or

(ii) On May 9, 1988, complied, with or without waivers, with the 1981 edition of the Life Safety Code and continues to remain in compliance with that edition of the Code.

(2) After consideration of State survey agency findings, CMS may waive specific provisions of the Life Safety Code which, if rigidly applied would result in unreasonable hardship upon the facility, but only if the waiver does not adversely affect the health and safety of residents or personnel.

(3) The provisions of the Life Safety Code do not apply in a State where CMS finds, in accordance with applicable provisions of sections 1819(d)(2)(B)(ii) and 1919(d)(2)(B)(ii) of the Act, that a fire and safety code imposed by State law adequately protects patients, residents and personnel in long term care facilities.

(4) A long-term care facility must be in compliance with the following provisions beginning on March 13, 2006:

(i) Chapter 19.3.6.3.2, exception number 2.

(ii) Chapter 19.2.9, Emergency Lighting.

(b) Emergency power. (1) An emergency electrical power system must supply power adequate at least for lighting all entrances and exits; equipment to maintain the fire detection, alarm, and extinguishing systems; and life support systems in the event the normal electrical supply is interrupted.

(2) When life support systems are used, the facility must provide emergency electrical power with an emergency generator (as defined in NFPA 99, Health Care Facilities) that is located on the premises.

(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

(2) Maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.

(d) Resident rooms. Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents.

(1) Bedrooms must --

(i) Accommodate no more than four residents;

(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms;

(iii) Have direct access to an exit corridor;

(iv) Be designed or equipped to assure full visual privacy for each resident;

(v) In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains;

(vi) Have at least one window to the outside; and

(vii) Have a floor at or above grade level.

(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

(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.

(3) CMS, or in the case of a nursing facility the survey agency, may permit variations in requirements specified in paragraphs (d)(1) (i) and (ii) of this section relating to rooms in individual cases when the facility demonstrates in writing that the variations --

(i) Are in accordance with the special needs of the residents; and

(ii) Will not adversely affect residents' health and safety.

(e) Toilet facilities. Each resident room must be equipped with or located near toilet and bathing facilities.

(f) Resident call system. The nurse's station must be equipped to receive resident calls through a communication system from --

(1) Resident rooms; and

(2) Toilet and bathing facilities.

(g) Dining and resident activities. The facility must provide one or more rooms designated for resident dining and activities. These rooms must --

(1) Be well lighted;

(2) Be well ventilated, with nonsmoking areas identified;

(3) Be adequately furnished; and

(4) Have sufficient space to accommodate all activities.

(h) Other environmental conditions. The facility must provide a safe, functional, sanitary, and comfortable environment for the residents, staff and the public. The facility must --

(1) Establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply;

(2) Have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two;

(3) Equip corridors with firmly secured handrails on each side; and

(4) Maintain an effective pest control program so that the facility is free of pests and rodents.

HISTORY:

[56 FR 48876, Sept. 26, 1991, as amended at 57 FR 43925, Sept. 23, 1992; 68 FR 1374, 1386, Jan. 10, 2003]

NOTES:

[EFFECTIVE DATE NOTE: 68 FR 1374, 1386, Jan. 10, 2003, amended paragraph (a), effective Mar. 11, 2003. "Compliance Dates: All health care facilities referenced in this rule must comply with the requirements of this final rule on September 11, 2003, except that compliance with § 403.744(c), § 416.44(b)(4), § 418.100(d)(4), § 460.72(b)(3), § 482.41(b)(1)(iv), § 483.70(a)(4), § 483.470(j)(2)(iii), and § 485.623(d)(5) is not required until March 13, 2006."]

§ 483.75 Administration.

A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

(a) Licensure. A facility must be licensed under applicable State and local law.

(b) Compliance with Federal, State, and local laws and professional standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.

(c) Relationship to other HHS regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of handicap (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455). Although these regulations are not in themselves considered requirements under this part, their violation may result in the termination or suspension of, or the refusal to grant or continue payment with Federal funds.

(d) Governing body. (1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and

(2) The governing body appoints the administrator who is --

(i) Licensed by the State where licensing is required; and

(ii) Responsible for management of the facility.

(e) Required training of nursing aides -- (1) Definitions.

Licensed health professional means a physician; physician assistant; nurse practitioner; physical, speech, or occupational therapist; physical or occupational therapy assistant; registered professional nurse; licensed practical nurse; or licensed or certified social worker.

Nurse aide means any individual providing nursing or nursing-related services to residents in a facility who is not a licensed health professional, a registered dietitian, or someone who volunteers to provide such services without pay. Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants as defined in § 488.301 of this chapter.

(2) General rule. A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless:

(i) That individual is competent to provide nursing and nursing related services; and

(ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §§ 483.151-483.154 of this part; or

(B) That individual has been deemed or determined competent as provided in § 483.150 (a) and (b).

(3) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (e)(2) (i) and (ii) of this section.

(4) Competency. A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual --

(i) Is a full-time employee in a State-approved training and competency evaluation program;

(ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or

(iii) Has been deemed or determined competent as provided in § 483.150 (a) and (b).

(5) Registry verification. Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless --

(i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or

(ii) The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.

(6) Multi-State registry verification. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual.

(7) Required retraining. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.

(8) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must --

(i) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year;

(ii) Address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and

(iii) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.

(f) Proficiency of Nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

(g) Staff qualifications. (1) The facility must employ on a full-time, part-time or consultant basis those

professionals necessary to carry out the provisions of these requirements.

(2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws.

(h) Use of outside resources. (1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or (with respect to services furnished to NF residents and dental services furnished to SNF residents) an agreement described in paragraph (h)(2) of this section.

(2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for --

(i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and

(ii) The timeliness of the services.

(i) Medical director. (1) The facility must designate a physician to serve as medical director.

(2) The medical director is responsible for --

(i) Implementation of resident care policies; and

(ii) The coordination of medical care in the facility.

(j) Level B requirement: Laboratory services. (1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

(i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter.

(ii) If the facility provides blood bank and transfusion services, it must meet the applicable requirements for laboratories specified in part 493 of this chapter.

(iii) If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of services in accordance with the requirements of part 493 of this chapter.

(iv) If the facility does not provide laboratory services on site, it must have an agreement to obtain these services from a laboratory that meets the applicable requirements of part 493 of this chapter.

(2) The facility must --

(i) Provide or obtain laboratory services only when ordered by the attending physician;

(ii) Promptly notify the attending physician of the findings;

(iii) Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance; and

(iv) File in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory.

(k) Radiology and other diagnostic services. (1) The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of

the services.

(i) If the facility provides its own diagnostic services, the services must meet the applicable conditions of participation for hospitals contained in § 482.26 of this subchapter.

(ii) If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare.

(2) The facility must --

(i) Provide or obtain radiology and other diagnostic services only when ordered by the attending physician;

(ii) Promptly notify the attending physician of the findings;

(iii) Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance; and

(iv) File in the resident's clinical record signed and dated reports of x-ray and other diagnostic services.

(1) Clinical records. (1) The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are --

(i) Complete;

(ii) Accurately documented;

(iii) Readily accessible; and

(iv) Systematically organized.

(2) Clinical records must be retained for --

(i) The period of time required by State law; or

(ii) Five years from the date of discharge when there is no requirement in State law; or

(iii) For a minor, three years after a resident reaches legal age under State law.

(3) The facility must safeguard clinical record information against loss, destruction, or unauthorized use;

(4) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is required by --

(i) Transfer to another health care institution;

(ii) Law;

(iii) Third party payment contract; or

(iv) The resident.

(5) The clinical record must contain --

(i) Sufficient information to identify the resident;

(ii) A record of the resident's assessments;

(iii) The plan of care and services provided;

(iv) The results of any preadmission screening conducted by the State; and

(v) Progress notes.

(m) Disaster and emergency preparedness. (1) The facility must have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents.

(2) The facility must train all employees in emergency procedures when they begin to work in the facility, periodically review the procedures with existing staff, and carry out unannounced staff drills using those procedures.

(n) Transfer agreement. (1) In accordance with section 1861(l) of the Act, the facility (other than a nursing facility which is located in a State on an Indian reservation) must have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably assures that --

(i) Residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician; and

(ii) Medical and other information needed for care and treatment of residents, and, when the transferring facility deems it appropriate, for determining whether such residents can be adequately cared for in a less expensive setting than either the facility or the hospital, will be exchanged between the institutions.

(2) The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible.

(o) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting of --

(i) The director of nursing services;

(ii) A physician designated by the facility; and

(iii) At least 3 other members of the facility's staff.

(2) The quality assessment and assurance committee --

(i) Meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and

(ii) Develops and implements appropriate plans of action to correct identified quality deficiencies.

(3) A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.

(4) Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

(p) Disclosure of ownership. (1) The facility must comply with the disclosure requirements of §§ 420.206 and 455.104 of this chapter.

(2) The facility must provide written notice to the State agency responsible for licensing the facility at the time of change, if a change occurs in --

- (i) Persons with an ownership or control interest, as defined in §§ 420.201 and 455.101 of this chapter;
 - (ii) The officers, directors, agents, or managing employees;
 - (iii) The corporation, association, or other company responsible for the management of the facility; or
 - (iv) The facility's administrator or director of nursing.
- (3) The notice specified in paragraph (p)(2) of this section must include the identity of each new individual or company.
- (q) Required training of feeding assistants. A facility must not use any individual working in the facility as a paid feeding assistant unless that individual has successfully completed a State-approved training program for feeding assistants, as specified in § 483.160 of this part.

HISTORY:

[56 FR 48877, Sept. 26, 1991, as amended at 56 FR 48918, Sept. 26, 1991; 57 FR 7136, Feb. 28, 1992; 57 FR 43925, Sept. 23, 1992; 59 FR 56237, Nov. 10, 1994; 63 FR 26252, 26311, May 12, 1998; 68 FR 55528, 55539, Sept. 26, 2003]

NOTES:

[EFFECTIVE DATE NOTE: 68 FR 55528, 55539, Sept. 26, 2003, amended this section, effective Oct. 27, 2003.]

§ 483.315 Specification of resident assessment instrument.

- (a) Statutory basis. Sections 1819(e)(5) and 1919(e)(5) of the Act require that a State specify the resident assessment instrument (RAI) to be used by long term care facilities in the State when conducting initial and periodic assessments of each resident's functional capacity, in accordance with § 483.20.
- (b) State options in specifying an RAI. The RAI that the State specifies must be one of the following:
- (1) The instrument designated by CMS.
 - (2) An alternate instrument specified by the State and approved by CMS, using the criteria specified in the State Operations Manual issued by CMS (CMS Pub. 7) which is available for purchase through the National Technical Information Service, 5285 Port Royal Rd., Springfield, VA 22151.
 - (c) State requirements in specifying an RAI.
 - (1) Within 30 days after CMS notifies the State of the CMS-designated RAI or changes to it, the State must do one of the following:
 - (i) Specify the CMS-designated RAI.
 - (ii) Notify CMS of its intent to specify an alternate instrument.
 - (2) Within 60 days after receiving CMS approval of an alternate RAI, the State must specify the RAI for use by all long term care facilities participating in the Medicare and Medicaid programs.
 - (3) After specifying an instrument, the State must provide periodic educational programs for facility staff to assist with implementation of the RAI.
 - (4) A State must audit implementation of the RAI through the survey process.

(5) A State must obtain approval from CMS before making any modifications to its RAI.

(6) A State must adopt revisions to the RAI that are specified by CMS.

(d) CMS-designated RAI. The CMS-designated RAI is published in the State Operations Manual issued by CMS (CMS Pub. 7), as updated periodically, and consists of the following:

(1) The minimum data set (MDS) and common definitions.

(2) The resident assessment protocols (RAPs) and triggers that are necessary to accurately assess residents, established by CMS.

(3) The quarterly review, based on a subset of the MDS specified by CMS.

(4) The requirements for use of the RAI that appear at § 483.20.

(e) Minimum data set (MDS). The MDS includes assessment in the following areas:

(1) Identification and demographic information, which includes information to identify the resident and facility, the resident's residential history, education, the reason for the assessment, guardianship status and information regarding advance directives, and information regarding mental health history.

(2) Customary routine, which includes the resident's lifestyle prior to admission to the facility.

(3) Cognitive patterns, which include memory, decision making, consciousness, behavioral measures of delirium, and stability of condition.

(4) Communication, which includes scales for measuring hearing and communication skills, information on how the resident expresses himself or herself, and stability of communicative ability.

(5) Vision pattern, which includes a scale for measuring vision and vision problems.

(6) Mood and behavior patterns, which include scales for measuring behavioral indicators and symptoms, and stability of condition.

(7) Psychosocial well-being, which includes the resident's interpersonal relationships and adjustment factors.

(8) Physical functioning and structural problems, which contains scales for measuring activities of daily living, mobility, potential for improvement, and stability of functioning.

(9) Continence, which includes assessment scales for bowel and bladder incontinence, continence patterns, interventions, and stability of continence status.

(10) Disease diagnoses and health conditions, which includes active medical diagnoses, physical problems, pain assessment, and stability of condition.

(11) Dental and nutritional status, which includes information on height and weight, nutritional problems and accommodations, oral care and problems, and measure of nutritional intake.

(12) Skin condition, which includes current and historical assessment of skin problems, treatments, and information regarding foot care.

(13) Activity pursuit, which gathers information on the resident's activity preferences and the amount of time spent participating in activities.

(14) Medications, which contains information on the types and numbers of medications the resident receives.

(15) Special treatments and procedures, which includes measurements of therapies, assessment of rehabilitation/restorative care, special programs and interventions, and information on hospital visits and physician involvement.

(16) Discharge potential, which assesses the possibility of discharging the resident and discharge status.

(17) Documentation of summary information regarding the additional assessment performed through the resident assessment protocols.

(18) Documentation of participation in assessment.

(f) Resident assessment protocols (RAPs). At a minimum, the RAPs address the following domains:

(1) Delirium.

(2) Cognitive loss.

(3) Visual function.

(4) Communication.

(5) ADL functional/rehabilitation potential.

(6) Urinary incontinence and indwelling catheter.

(7) Psychosocial well-being.

(8) Mood state.

(9) Behavioral symptoms.

(10) Activities.

(11) Falls.

(12) Nutritional status.

(13) Feeding tubes.

(14) Dehydration/fluid maintenance.

(15) Dental care.

(16) Pressure ulcers.

(17) Psychotropic drug use.

(18) Physical restraints.

(g) Criteria for CMS approval of alternate instrument. To receive CMS approval, a State's alternate instrument must use the standardized format, organization, item labels and definitions, and instructions specified by CMS in the latest issuance of the State Operations Manual issued by CMS (CMS Pub. 7).

(h) State MDS collection and data base requirements. (1) As part of facility survey responsibilities, the State

must establish and maintain an MDS Database, and must do the following:

- (i) Use a system to collect, store, and analyze data that is developed or approved by CMS.
- (ii) Obtain CMS approval before modifying any parts of the CMS standard system other than those listed in paragraph (h)(2) of this section (which may not be modified).
- (iii) Specify to a facility the method of transmission of data to the State, and instruct the facility on this method.
- (iv) Upon receipt of data from a facility, edit the data, as specified by CMS, and ensure that a facility resolves errors.
- (v) At least monthly, transmit to CMS all edited MDS records received during that period, according to formats specified by CMS, and correct and retransmit rejected data as needed.
- (vi) Analyze data and generate reports, as specified by CMS.

(2) The State may not modify any aspect of the standard system that pertains to the following:

- (i) Standard approvable RAI criteria specified in the State Operations Manual issued by CMS (CMS Pub. 7) (MDS item labels and definitions, RAPs and utilization guidelines).
- (ii) Standardized record formats and validation edits specified in the State Operations Manual issued by CMS (CMS Pub. 7).
- (iii) Standard facility encoding and transmission methods specified in the State Operations Manual issued by CMS (CMS Pub. 7).

(i) State identification of agency that collects RAI data. The State must identify the component agency that collects RAI data, and ensure that this agency restricts access to the data except for the following:

- (1) Reports that contain no resident-identifiable data.
- (2) Transmission of data and reports to CMS.
- (3) Transmission of data and reports to the State agency that conducts surveys to ensure compliance with Medicare and Medicaid participation requirements, for purposes related to this function.
- (4) Transmission of data and reports to the State Medicaid agency for purposes directly related to the administration of the State Medicaid plan.
- (5) Transmission of data and reports to other entities only when authorized as a routine use by CMS.

(j) Resident-identifiable data. (1) The State may not release information that is resident-identifiable to the public.

(2) The State may not release RAI data that is resident-identifiable except in accordance with a written agreement under which the recipient agrees to be bound by the restrictions described in paragraph (i) of this section.

HISTORY:

[62 FR 67174, 67212, Dec. 23, 1997]

Attachment G:

DC Law



2 of 19 DOCUMENTS

LEXIS DISTRICT OF COLUMBIA CODE ANNOTATED
Copyright 2012 by Matthew Bender & Company, Inc.,
a member of the LexisNexis Group.
All rights reserved.

*** Current through May 30, 2012, and through D.C. Acts 19-375 and 19-377 ***
*** Annotations current through May 1, 2012 ***

DIVISION I. GOVERNMENT OF DISTRICT
TITLE 7. HUMAN HEALTH CARE AND SAFETY
SUBTITLE A. GENERAL
CHAPTER 7. LONG-TERM CARE OMBUDSMAN PROGRAM
SUBCHAPTER I. DEFINITIONS

GO TO DISTRICT OF COLUMBIA CODE ARCHIVE DIRECTORY

D.C. Code § 7-701.01 (2012)

THIS SECTION HAS MORE THAN ONE DOCUMENT WITH VARYING EFFECTIVE DATES.

§ 7-701.01. Definitions [Formerly § 6-3501] [Applicable when contingency met]

For the purposes of this chapter, the term:

- (1) "Administrator" means the person who is responsible for the day-to-day operation and management of a long-term care facility, including, in the case of a community residence facility, the residence director.
- (2) "Court" means the Superior Court of the District of Columbia.
- (3) "Department of Consumer and Regulatory Affairs" means the District of Columbia Department of Consumer and Regulatory Affairs established pursuant to Reorganization Plan No. 1 of 1983.
- (3A) "Department of Health, Health Regulations and Licensing Administration" means the administrative office established in January 17, 2007, under the Department of Health.
- (4) "Department of Human Services" means the District of Columbia Department of Human Services established pursuant to Reorganization Plan No. 2 of 1979 and Reorganization Plan No. 3 of 1986.
- (4A) "Department of Mental Health" means the Department of Mental Health established as a separate cabinet-level agency pursuant to § 7-1131.03.
- (5) "Designee" means a person who:
 - (A) Has received a minimum of 15 hours of certified training in accordance with § 7-702.04(a)(15);

D.C. Code § 7-701.01

(B) Is an employee or volunteer of the program established pursuant to § 7-702.01 or has written authorization to act on behalf of the ombudsman pursuant to § 7-702.04(a)(3).

(6) "Director" means the Executive Director of the District of Columbia Office on Aging established by § 7-503.02.

(6A) "Home care agency" shall have the same meaning as provided in § 44-501(a)(7).

(7) "Long-term care facility" means:

(A) A "community residence facility" as defined in § 44-501(a)(4);

(B) A "nursing home" as defined in § 44-501(a)(3); or

(C) An "assisted living residence" as defined in § 44-101.01(4).

(7A) "Long-term care services" means services received at a long-term care facility and services provided to residents in the community who need a nursing home level of care and receive home health care through the Medicaid Elderly and Physically Disabled Waiver.

(8) "Ombudsman" means the District of Columbia Long-Term Care Ombudsman established by § 7-702.02(a) and designated under § 307(a)(12) of the Older Americans Act of 1965; (42 U.S.C.S. § 3027(a)(12)), to perform the mandated functions of the Long-Term Care Ombudsman Program.

(9) "Office on Aging" means the District of Columbia Office on Aging established by § 7-503.01.

(10) "Person" means an individual, an agent, a corporation, a partnership, or any other organizational entity.

(11) "Program" means the District of Columbia Long-Term Care Ombudsman Program established by § 7-702.01.

(12) "Record" means:

(A) Medical, social, personal, or financial information maintained by a health-care facility covered by the Health-Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983, or by a District of Columbia ("District") government agency that has responsibility for the care and maintenance of a resident in a long-term care facility; and

(B) An administrative record, cost or incident report, or a report of a civil infraction, inspection, or deficiency maintained by a long-term care facility or a District government agency.

(13) "Resident" means a resident of a long-term care facility or an individual receiving long-term care services from a home care agency through the Medicaid Elderly and Physically Disabled Waiver.

(14) "Representative of a resident" means:

(A) A person who is knowledgeable about the circumstances of a resident and has been designated by that resident to represent him or her; or

(B) A person, other than a facility, who has been appointed by a court to administer the financial or personal affairs of a resident or to protect and advocate for the rights of a resident; or

(C) The ombudsman or his or her designee, if no person has been designated or appointed in accordance with subparagraph (A) or (B) of this paragraph.

HISTORY: 1981 Ed., § 6-3501; Mar. 16, 1989, D.C. Law 7-218, § 101, 36 DCR 534; Mar. 12, 2011, D.C. Law 18-321, § 2(a), 57 DCR 12438; Mar. 14, 2012, D.C. Law 19-111, § 2(a), 59 DCR 453.

NOTES: EFFECT OF AMENDMENTS. --The 2012 amendment by D.C. Law 19-111 added (6A) and (7A); and added "or an individual receiving long-term care services from a home care agency through the Medicaid Elderly and Physically Disabled Waiver" in (13).

LEGISLATIVE HISTORY OF LAW 19-111. --Law 19-111, the "Long-Term Care Ombudsman Program Amendment Act of 2012," was introduced in Council and assigned Bill No. 19-360. The Bill was adopted on first and second readings on Dec. 6, 2011, and Jan. 4, 2012, respectively. Signed by the Mayor on Jan. 20, 2012, it was assigned Act No. 19-286 and transmitted to Congress for its review. D.C. Law 19-111 became effective on Mar. 14, 2012.

EDITOR'S NOTES. --Section 3 of D.C. Law 19-111 provided that the act shall apply upon the inclusion of its fiscal effect in an approved budget and financial plan.

For text of section applicable until the inclusion of the fiscal effect of D.C. Law 19-111 in an approved budget and financial plan, see the first version.

LexisNexis 50 State Surveys, Legislation & Regulations

Healthcare Ombudsing



3 of 19 DOCUMENTS

LEXIS DISTRICT OF COLUMBIA CODE ANNOTATED
Copyright 2012 by Matthew Bender & Company, Inc.,
a member of the LexisNexis Group.
All rights reserved.

*** Current through May 30, 2012, and through D.C. Acts 19-375 and 19-377 ***
*** Annotations current through May 1, 2012 ***

DIVISION I. GOVERNMENT OF DISTRICT
TITLE 7. HUMAN HEALTH CARE AND SAFETY
SUBTITLE A. GENERAL
CHAPTER 7. LONG-TERM CARE OMBUDSMAN PROGRAM
SUBCHAPTER II. ESTABLISHMENT OF A LONG-TERM CARE OMBUDSMAN PROGRAM

GO TO DISTRICT OF COLUMBIA CODE ARCHIVE DIRECTORY

D.C. Code § 7-702.01 (2012)

§ 7-702.01. Purpose and functions [Formerly § 6-3511]

There is established a Long-Term Care Ombudsman Program for the District of Columbia within the Office on Aging. The program shall provide a comprehensive continuum of advocacy services for older persons and other persons who are residents in the District, which shall include:

- (1) Advocating for the rights of older persons and other persons who are residents;
- (2) Investigating and resolving any complaint made by or on behalf of an older person or other person who is a resident; and
- (3) Monitoring the quality of care, services provided, and quality of life experienced by older persons and residents to ensure that the care and services are in accordance with applicable District and federal laws.

HISTORY: 1981 Ed., § 6-3511; Mar. 16, 1989, D.C. Law 7-218, § 201, 36 DCR 534.

NOTES: SECTION REFERENCES. --This section is referenced in § 7-701.01.

LEGISLATIVE HISTORY OF LAW 7-218. --See note to § 7-701.01

LexisNexis 50 State Surveys, Legislation & Regulations

Healthcare Ombudsing



4 of 19 DOCUMENTS

LEXIS DISTRICT OF COLUMBIA CODE ANNOTATED

Copyright 2012 by Matthew Bender & Company, Inc.,
a member of the LexisNexis Group.
All rights reserved.

*** Current through May 30, 2012, and through D.C. Acts 19-375 and 19-377 ***

*** Annotations current through May 1, 2012 ***

DIVISION I. GOVERNMENT OF DISTRICT
TITLE 7. HUMAN HEALTH CARE AND SAFETY
SUBTITLE A. GENERAL

CHAPTER 7. LONG-TERM CARE OMBUDSMAN PROGRAM
SUBCHAPTER II. ESTABLISHMENT OF A LONG-TERM CARE OMBUDSMAN PROGRAM

GO TO DISTRICT OF COLUMBIA CODE ARCHIVE DIRECTORY

D.C. Code § 7-702.02 (2012)

§ 7-702.02. Long-Term Care Ombudsman; appointment; vacancy [Formerly § 6-3512]

(a) The program shall be administered by a full-time ombudsman and shall be under the Director of the Office on Aging ("Director") or his or her designee. The Director shall appoint the ombudsman for a term of 2 years and approve of the designee of the ombudsman. The ombudsman shall be a resident of the District.

(b) The Director may contract with a nonprofit provider, other than the District government, to operate the program. The provider shall have experience advocating for the rights of older persons and residents. The ombudsman shall be an employee of the nonprofit provider.

(c) The Director shall ensure that the following are provided to the ombudsman or his or her designee to implement the provisions of this chapter:

- (1) Legal counsel for advice and consultation;
- (2) Legal representation, if legal action is taken to implement the provisions of this chapter; and
- (3) Clerical and administrative support staff and materials.

(d) The primary responsibility of the ombudsman or his or her designee shall be the investigation and resolution of any complaint made by or on behalf of a resident.

HISTORY: 1981 Ed., § 6-3512; Mar. 16, 1989, D.C. Law 7-218, § 202, 36 DCR 534.

NOTES: SECTION REFERENCES. --This section is referenced in § 7-701.01.

LEGISLATIVE HISTORY OF LAW 7-218. --See note to § 7-701.01.

D.C. Code § 7-702.02

LexisNexis 50 State Surveys, Legislation & Regulations

Healthcare Ombudsing

CITED in *Newman v. Kelly*, 848 F. Supp. 228 (D.D.C. 1994).



5 of 19 DOCUMENTS

LEXIS DISTRICT OF COLUMBIA CODE ANNOTATED

Copyright 2012 by Matthew Bender & Company, Inc.,

a member of the LexisNexis Group.

All rights reserved.

*** Current through May 30, 2012, and through D.C. Acts 19-375 and 19-377 ***

*** Annotations current through May 1, 2012 ***

DIVISION I. GOVERNMENT OF DISTRICT

TITLE 7. HUMAN HEALTH CARE AND SAFETY

SUBTITLE A. GENERAL

CHAPTER 7. LONG-TERM CARE OMBUDSMAN PROGRAM

SUBCHAPTER II. ESTABLISHMENT OF A LONG-TERM CARE OMBUDSMAN PROGRAM

GO TO DISTRICT OF COLUMBIA CODE ARCHIVE DIRECTORY

D.C. Code § 7-702.03 (2012)

§ 7-702.03. Same -- Training and experience [Formerly § 6-3513]

(a) The ombudsman shall have training and experience in the following areas:

(1) Gerontology, long-term care, health care, or relevant social services program;

(2) The legal system;

(3) Dispute resolution techniques, including investigation, mediation, or negotiation; and

(4) Long-term care advocacy.

(b) No person who has been employed by a long-term care facility or a corporation that directly or indirectly owned or operated a long-term care facility within the past 2 years shall be an ombudsman.

(c) Neither the ombudsman nor any member of his or her immediate family shall have any pecuniary interest in a long-term care facility.

HISTORY: 1981 Ed., § 6-3513; Mar. 16, 1989, D.C. Law 7-218, § 203, 36 DCR 534.

NOTES: LEGISLATIVE HISTORY OF LAW 7-218. --See note to § 7-701.01.

LexisNexis 50 State Surveys, Legislation & Regulations

Healthcare Ombudsing



6 of 19 DOCUMENTS

LEXIS DISTRICT OF COLUMBIA CODE ANNOTATED
Copyright 2012 by Matthew Bender & Company, Inc.,
a member of the LexisNexis Group.
All rights reserved.

*** Current through May 30, 2012, and through D.C. Acts 19-375 and 19-377 ***
*** Annotations current through May 1, 2012 ***

DIVISION I. GOVERNMENT OF DISTRICT
TITLE 7. HUMAN HEALTH CARE AND SAFETY
SUBTITLE A. GENERAL
CHAPTER 7. LONG-TERM CARE OMBUDSMAN PROGRAM
SUBCHAPTER II. ESTABLISHMENT OF A LONG-TERM CARE OMBUDSMAN PROGRAM

GO TO DISTRICT OF COLUMBIA CODE ARCHIVE DIRECTORY

D.C. Code § 7-702.04 (2012)

THIS SECTION HAS MORE THAN ONE DOCUMENT WITH VARYING EFFECTIVE DATES.

§ 7-702.04. Same -- Powers and duties [Formerly § 6-3514] [Applicable until contingency met]

(a) The ombudsman shall:

- (1) Investigate and resolve complaints or concerns made by or on behalf of residents;
- (2) Promote the well-being and quality of life of each resident;
- (3) Encourage the development and the expansion of the activities of the program in all wards of the District, sufficient to serve the residents in those wards;
- (4) Submit to the Office on Aging for submission to the Council and the Mayor annual reports that document complaints received and resolved and recommend policy, regulatory, or legislative changes;
- (5) Enter into, on behalf of the Office on Aging and with the approval of the Director, written agreements of understanding, cooperation, and collaboration with any District government agency that provides funding, oversight, or inspection of, or operates a long-term care facility;
- (6) Establish and implement program policies and procedures to elicit, receive, investigate, verify, refer, and resolve residents' complaints;
- (7) Develop an on-going program for publicizing the program;
- (8) Identify, document, and address solutions to problems affecting residents;

D.C. Code § 7-702.04

(9) Serve as the legal representative for residents, pursuant to §§ 44-1003.02(e), 44-1003.03(a)(1), and 44-1003.07(a) and (b);

(10) Repealed;

(11) Establish a uniform system to record data on complaints and conditions relating to long-term care services;

(12) Monitor the development and implementation of district and federal laws, rules, regulations, and policies that affect residents;

(13) Make specific recommendations, through the Office on Aging, to the operator or agent of the operator of any long-term care facility, whenever the ombudsman believes that conditions exist that adversely affect residents' health, safety, welfare, or rights;

(14) Report to the appropriate enforcement agency any act of an operator of a long-term care facility that the ombudsman believes to be a violation of an applicable federal or District law, regulation, or rule;

(15) Establish and conduct a training program for persons employed by or associated with the program, which shall include training in the following areas:

(A) The review of medical records;

(B) Regulatory requirements for long-term care facilities;

(C) Confidentiality of records;

(D) Techniques of complaint investigation;

(E) The effects of institutionalization; and

(F) The special needs of the elderly;

(16) Assist in the formation, development, and use by residents, their families, and friends of forums that permit residents, their families, and friends to discuss and communicate, on a regular and continuing basis, their views on the strengths and weaknesses of the operation of the facility, the quality of care provided, and the quality of life fostered in long-term care facilities;

(17) Establish and maintain procedures to protect the confidentiality of the records of residents and long-term care facilities where access is authorized pursuant to § 7-703.02;

(18) Prohibit any employee, designee, or representative of the program from investigating any complaint or representing the ombudsman, unless that person has received training in accordance with paragraph (15) of this subsection; and

(19) Designate local ombudsman programs to act on behalf of the ombudsman within specific geographical areas.

(b) No person, agency, or long-term care facility shall obstruct the ombudsman or his or her designee from the lawful performance of any duty or the exercise of any power.

HISTORY: 1981 Ed., § 6-3514; Mar. 16, 1989, D.C. Law 7-218, § 204, 36 DCR 534; Feb. 5, 1994, D.C. Law 10-68, § 18, 40 DCR 6311; Mar. 12, 2011, D.C. Law 18-321, § 2(b), 57 DCR 12438.

NOTES: SECTION REFERENCES. --This section is referenced in § 7-701.01 and § 7-702.06.

D.C. Code § 7-702.04

EFFECT OF AMENDMENTS. --The 2011 amendment by D.C. Law 18-321 rewrote (a)(1), which formerly read: "Investigate and resolve complaints and concerns made by or on behalf of older persons and other residents in the District"; rewrote (a)(4), which formerly read: "Submit annually, to the Office on Aging for submission to the Council and the Mayor, a written report documenting the complaints received and resolved, and recommending policy, regulatory, or legislative changes"; made stylistic changes in (a)(6); repealed (a)(10); rewrote (a)(11), which formerly read: "Establish a system for coordinating a uniform District-wide system to record data on complaints and conditions in long-term care facilities"; and substituted "conditions exist that adversely affect residents' health, safety, welfare, or rights" for "conditions which adversely affect the health, safety, welfare, or rights of a resident exist within the long-term care facility" in (a)(13).

LEGISLATIVE HISTORY OF LAW 7-218. --See note to § 7-701.01.

LEGISLATIVE HISTORY OF LAW 10-68. --Law 10-68, the "Technical Amendments Act of 1993," was introduced in Council and assigned Bill No. 10-166. The Bill was adopted on first and second readings on June 29, 1993, and July 13, 1993, respectively. Signed by the Mayor on Aug. 23, 1993, it was assigned Act No. 10-107 and transmitted to both Houses of Congress for its review. D.C. Law 10-68 became effective on Feb. 5, 1994.

LEGISLATIVE HISTORY OF LAW 18-321. --See note to § 7-701.01.

EDITOR'S NOTES. --For text of section applicable upon the inclusion of the fiscal effect of D.C. Law 19-111 in an approved budget and financial plan, see the second version.

LexisNexis 50 State Surveys, Legislation & Regulations

Healthcare Ombudsing



7 of 19 DOCUMENTS

LEXIS DISTRICT OF COLUMBIA CODE ANNOTATED

Copyright 2012 by Matthew Bender & Company, Inc.,

a member of the LexisNexis Group.

All rights reserved.

*** Current through May 30, 2012, and through D.C. Acts 19-375 and 19-377 ***

*** Annotations current through May 1, 2012 ***

DIVISION I. GOVERNMENT OF DISTRICT

TITLE 7. HUMAN HEALTH CARE AND SAFETY

SUBTITLE A. GENERAL

CHAPTER 7. LONG-TERM CARE OMBUDSMAN PROGRAM

SUBCHAPTER II. ESTABLISHMENT OF A LONG-TERM CARE OMBUDSMAN PROGRAM

GO TO DISTRICT OF COLUMBIA CODE ARCHIVE DIRECTORY

D.C. Code § 7-702.04 (2012)

THIS SECTION HAS MORE THAN ONE DOCUMENT WITH VARYING EFFECTIVE DATES.

§ 7-702.04. Same -- Powers and duties [Formerly § 6-3514] [Applicable when contingency met]

(a) The ombudsman shall:

(1) Receive, investigate, and resolve complaints or concerns made by or on behalf of residents;

(2) Promote the well-being and quality of life of each resident;

(3) Encourage the development and the expansion of the activities of the program in all wards of the District, sufficient to serve the residents in those wards;

(4) Submit to the Office on Aging for submission to the Council and the Mayor annual reports that document complaints received and resolved and recommend policy, regulatory, or legislative changes;

(5) Enter into, on behalf of the Office on Aging and with the approval of the Director, written agreements of understanding, cooperation, and collaboration with any District government agency that provides funding, oversight, or inspection of, or operates a long-term care facility;

(6) Establish and implement program policies and procedures to elicit, receive, investigate, verify, refer, and resolve residents' complaints;

(7) Develop an on-going program for publicizing the program;

(8) Identify, document, and address solutions to problems affecting residents;

D.C. Code § 7-702.04

- (9) Serve as the legal representative for residents, pursuant to §§ 44-1003.02(e), 44-1003.03(a)(1), and 44-1003.07(a) and (b);
- (10) Repealed;
- (11) Establish a uniform system to record data on complaints and conditions relating to long-term care services;
- (12) Monitor the development and implementation of district and federal laws, rules, regulations, and policies that affect residents;
- (13) Make specific recommendations, through the Office on Aging, to the operator or agent of the operator of any long-term care facility, whenever the ombudsman believes that conditions exist that adversely affect residents' health, safety, welfare, or rights;
- (14) Report to the appropriate enforcement agency any act of an operator of a long-term care facility or home care agency that the ombudsman believes to be a violation of an applicable federal or District law, regulation, or rule;
- (15) Establish and conduct a training program for persons employed by or associated with the program, which shall include training in the following areas:
- (A) The review of medical records;
 - (B) Regulatory requirements for long-term care facilities;
 - (C) Confidentiality of records;
 - (D) Techniques of complaint investigation;
 - (E) The effects of institutionalization; and
 - (F) The special needs of the elderly;
- (16) Assist in the formation, development, and use by residents, their families, and friends of forums that permit residents, their families, and friends to discuss and communicate, on a regular and continuing basis, their views on the strengths and weaknesses of the operation of the facility, the quality of care provided, and the quality of life fostered in long-term care facilities;
- (17) Establish and maintain procedures to protect the confidentiality of the records of residents and long-term care facilities where access is authorized pursuant to § 7-703.02;
- (18) Prohibit any employee, designee, or representative of the program from investigating any complaint or representing the ombudsman, unless that person has received training in accordance with paragraph (15) of this subsection; and
- (19) Designate local ombudsman programs to act on behalf of the ombudsman within specific geographical areas.
- (b) No person, agency, or long-term care facility shall obstruct the ombudsman or his or her designee from the lawful performance of any duty or the exercise of any power.

HISTORY: 1981 Ed., § 6-3514; Mar. 16, 1989, D.C. Law 7-218, § 204, 36 DCR 534; Feb. 5, 1994, D.C. Law 10-68, § 18, 40 DCR 6311; Mar. 12, 2011, D.C. Law 18-321, § 2(b), 57 DCR 12438; Mar. 14, 2012, D.C. Law 19-111, § 2(b), 59 DCR 453.

NOTES: EFFECT OF AMENDMENTS. --The 2012 amendment by D.C. Law 19-111 added "Receive" in (a)(1); and added "or home care agency" in (a)(14).

LEGISLATIVE HISTORY OF LAW 19-111. --See note to § 7-701.01.

EDITOR'S NOTES. --Section 3 of D.C. Law 19-111 provided that the act shall apply upon the inclusion of its fiscal effect in an approved budget and financial plan.

For text of section applicable until the inclusion of the fiscal effect of D.C. Law 19-111 in an approved budget and financial plan, see the first version.

LexisNexis 50 State Surveys, Legislation & Regulations

Healthcare Ombudsing



8 of 19 DOCUMENTS

LEXIS DISTRICT OF COLUMBIA CODE ANNOTATED
Copyright 2012 by Matthew Bender & Company, Inc.,
a member of the LexisNexis Group.
All rights reserved.

*** Current through May 30, 2012, and through D.C. Acts 19-375 and 19-377 ***
*** Annotations current through May 1, 2012 ***

DIVISION I. GOVERNMENT OF DISTRICT
TITLE 7. HUMAN HEALTH CARE AND SAFETY
SUBTITLE A. GENERAL
CHAPTER 7. LONG-TERM CARE OMBUDSMAN PROGRAM
SUBCHAPTER II. ESTABLISHMENT OF A LONG-TERM CARE OMBUDSMAN PROGRAM

GO TO DISTRICT OF COLUMBIA CODE ARCHIVE DIRECTORY

D.C. Code § 7-702.05 (2012)

§ 7-702.05. Complaint investigation [Formerly § 6-3515]

(a) The ombudsman and his or her designee shall have access to any record that is necessary to carry out his or her responsibilities under this chapter.

(b) The ombudsman or his or her designee may initiate an investigation of a long-term care facility independent of the receipt of a specific complaint.

HISTORY: 1981 Ed., § 6-3515; Mar. 16, 1989, D.C. Law 7-218, § 205, 36 DCR 534.

NOTES: LEGISLATIVE HISTORY OF LAW 7-218. --See note to § 7-701.01.

LexisNexis 50 State Surveys, Legislation & Regulations

Healthcare Ombudsing



9 of 19 DOCUMENTS

LEXIS DISTRICT OF COLUMBIA CODE ANNOTATED

Copyright 2012 by Matthew Bender & Company, Inc.,

a member of the LexisNexis Group.

All rights reserved.

*** Current through May 30, 2012, and through D.C. Acts 19-375 and 19-377 ***

*** Annotations current through May 1, 2012 ***

DIVISION I. GOVERNMENT OF DISTRICT

TITLE 7. HUMAN HEALTH CARE AND SAFETY

SUBTITLE A. GENERAL

CHAPTER 7. LONG-TERM CARE OMBUDSMAN PROGRAM

SUBCHAPTER II. ESTABLISHMENT OF A LONG-TERM CARE OMBUDSMAN PROGRAM

GO TO DISTRICT OF COLUMBIA CODE ARCHIVE DIRECTORY

D.C. Code § 7-702.06 (2012)

§ 7-702.06. Confidentiality of records and identities of residents [Formerly § 6-3516]

(a) The program shall protect the confidentiality of the records (electronic or hard copy) of the residents and employees.

(b) No information or records (electronic or hard copy) maintained by the program shall be disclosed to the public.

(c) Except as provided in subsection (d) of this section, the program shall not disclose the identity of any complainant, resident involved in a complaint, witness, or representative of a resident, unless the complainant, resident, or representative of a resident authorizes the disclosure.

(d) A court may order the disclosure of information made confidential under this chapter if it determines that the disclosure is necessary to enforce this chapter.

(e) A communication between a resident and a person who has access under § 7-703.01 shall be confidential, unless the resident authorizes the release of the communication or unless disclosure is authorized under § 7-702.04(a)(1) or subsection (d) of this section.

HISTORY: 1981 Ed., § 6-3516; Mar. 16, 1989, D.C. Law 7-218, § 206, 36 DCR 534; Mar. 12, 2011, D.C. Law 18-321, § 2(c), 57 DCR 12438.

NOTES: SECTION REFERENCES. --This section is referenced in § 7-704.01.

EFFECT OF AMENDMENTS. --The 2011 amendment by D.C. Law 18-321 added "(electronic or hard copy)" in (a) and (b); added "Except as provided in subsection (d) of this section" at the beginning of (c); and added (d) and (e).

LEGISLATIVE HISTORY OF LAW 7-218. --See note to § 7-701.01.

D.C. Code § 7-702.06

LEGISLATIVE HISTORY OF LAW 18-321. --See note to § 7-701.01.

LexisNexis 50 State Surveys, Legislation & Regulations

Healthcare Ombudsing



10 of 19 DOCUMENTS

LEXIS DISTRICT OF COLUMBIA CODE ANNOTATED

Copyright 2012 by Matthew Bender & Company, Inc.,

a member of the LexisNexis Group.

All rights reserved.

*** Current through May 30, 2012, and through D.C. Acts 19-375 and 19-377 ***

*** Annotations current through May 1, 2012 ***

DIVISION I. GOVERNMENT OF DISTRICT

TITLE 7. HUMAN HEALTH CARE AND SAFETY

SUBTITLE A. GENERAL

CHAPTER 7. LONG-TERM CARE OMBUDSMAN PROGRAM

SUBCHAPTER II. ESTABLISHMENT OF A LONG-TERM CARE OMBUDSMAN PROGRAM

GO TO DISTRICT OF COLUMBIA CODE ARCHIVE DIRECTORY

D.C. Code § 7-702.07 (2012)

§ 7-702.07. Immunity from liability [Formerly § 6-3517]

(a) No employee, designee, or representative of the program shall be held liable for the good faith performance of responsibilities under this chapter, except that no immunity shall extend to criminal acts.

(b) Repealed.

(c) No communication made by the ombudsman or his or her designee, if reasonably related to the requirements of his or her responsibilities, shall be subject to civil action.

(d) Repealed.

HISTORY: 1981 Ed., § 6-3517; Mar. 16, 1989, D.C. Law 7-218, § 207, 36 DCR 534; Mar. 12, 2011, D.C. Law 18-321, § 2(d), 57 DCR 12438.

NOTES: EFFECT OF AMENDMENTS. --The 2011 amendment by D.C. Law 18-321 repealed (b) and (d); and deleted "for libel or slander" at the end of (c).

LEGISLATIVE HISTORY OF LAW 7-218. --See note to § 7-701.01.

LEGISLATIVE HISTORY OF LAW 18-321. --See note to § 7-701.01.

LexisNexis 50 State Surveys, Legislation & Regulations

Healthcare Ombudsing



11 of 19 DOCUMENTS

LEXIS DISTRICT OF COLUMBIA CODE ANNOTATED
Copyright 2012 by Matthew Bender & Company, Inc.,
a member of the LexisNexis Group.
All rights reserved.

*** Current through May 30, 2012, and through D.C. Acts 19-375 and 19-377 ***
*** Annotations current through May 1, 2012 ***

DIVISION I. GOVERNMENT OF DISTRICT
TITLE 7. HUMAN HEALTH CARE AND SAFETY
SUBTITLE A. GENERAL
CHAPTER 7. LONG-TERM CARE OMBUDSMAN PROGRAM
SUBCHAPTER III. ACCESS FOR THE LONG-TERM CARE OMBUDSMAN AND DESIGNEES

GO TO DISTRICT OF COLUMBIA CODE ARCHIVE DIRECTORY

D.C. Code § 7-703.01 (2012)

§ 7-703.01. Access to long-term care facilities [Formerly § 6-3521]

- (a) The operator of a long-term care facility shall permit the ombudsman or his or her designee access to the facility to:
- (1) Visit, talk with, or make personal, social, or legal services available to all residents, or investigate complaints;
 - (2) Inform residents of their rights or entitlements, and corresponding obligations under applicable federal and District law by means of distribution of educational materials or discussion in groups and with individual residents;
 - (3) Assist residents in asserting their legal rights regarding claims for public assistance, medical assistance, social security benefits, or other matters in which residents are aggrieved; and
 - (4) Inspect all areas of the facility, except the living area of a resident who protests inspection.
- (b) Access under this section shall be permitted to the ombudsman or his or her designee 24 hours a day, 7 days a week.
- (c) Upon entering a long-term care facility in accordance with this section, the ombudsman or his or her designee shall promptly advise 1 of the following persons of his or her presence:
- (1) The administrator or acting administrator;
 - (2) The residence director; or
 - (3) Another available supervisory agent of the facility.
- (d) A person who has access under this section shall not enter the living area of a resident without identifying him or herself to the resident and receiving the permission of the resident to enter.

(e) A resident shall have the right to terminate, at any time, any visit by a person or representative of the program who has access under this section.

(f) Repealed.

(g) No resident shall be punished or harassed by the operator of a facility or an agent or employee of the operator of the facility because of efforts of the resident to avail himself or herself of his or her rights pursuant to this chapter.

(h) A written notice, prescribed by the ombudsman, that describes the rights of a resident pursuant to this chapter and the telephone number of the ombudsman shall be posted in a conspicuous place at or near the entrance to the long-term care facility and on each floor of the facility.

(i) The operator of a long-term care facility shall provide each resident a personal written copy of the notice required under subsection (h) of this section. Each new resident shall be provided a written copy of the notice upon admission.

(j) If a resident cannot read the notice required under subsection (h) of this section, the contents of the notice shall be communicated to that resident orally and in writing.

(k) The written notice required under subsection (h) of this section shall be provided in the appropriate language to those residents who do not speak or understand English.

(l) A notation that personal notice, as required by subsection (i) of this section, has been provided shall be entered in the clinical record of each resident.

(m) Nothing in this section shall be construed to restrict any right or privilege of a resident to receive a visitor who is not a representative of a community organization, legal services program, or the program.

HISTORY: 1981 Ed., § 6-3521; Mar. 16, 1989, D.C. Law 7-218, § 301, 36 DCR 534; Mar. 12, 2011, D.C. Law 18-321, § 2(f), 57 DCR 12438.

NOTES: SECTION REFERENCES. --This section is referenced in § 7-702.06.

EFFECT OF AMENDMENTS. --The 2011 amendment by D.C. Law 18-321 substituted "to the ombudsman or his or her designee 24 hours a day, 7 days a week" in (b); and repealed former (f), which read: "A communication between a resident and a person who has access under this section shall be confidential, unless the resident authorizes the release of the communication."

LEGISLATIVE HISTORY OF LAW 7-218. --See note to § 7-701.01.

LEGISLATIVE HISTORY OF LAW 18-321. --See note to § 7-701.01.

EDITOR'S NOTES. --Section 2(e) of D.C. Law 18-321 rewrote the subchapter heading, which formerly read: "Access to Long-Term Care Facilities and to Records."

LexisNexis 50 State Surveys, Legislation & Regulations

Healthcare Ombudsing



12 of 19 DOCUMENTS

LEXIS DISTRICT OF COLUMBIA CODE ANNOTATED

Copyright 2012 by Matthew Bender & Company, Inc.,
a member of the LexisNexis Group.

All rights reserved.

*** Current through May 30, 2012, and through D.C. Acts 19-375 and 19-377 ***

*** Annotations current through May 1, 2012 ***

DIVISION I. GOVERNMENT OF DISTRICT

TITLE 7. HUMAN HEALTH CARE AND SAFETY

SUBTITLE A. GENERAL

CHAPTER 7. LONG-TERM CARE OMBUDSMAN PROGRAM

SUBCHAPTER III. ACCESS FOR THE LONG-TERM CARE OMBUDSMAN AND DESIGNEES

GO TO DISTRICT OF COLUMBIA CODE ARCHIVE DIRECTORY

D.C. Code § 7-703.02 (2012)

THIS SECTION HAS MORE THAN ONE DOCUMENT WITH VARYING EFFECTIVE DATES.

§ 7-703.02. Access to records [Formerly § 6-3522] [Applicable until contingency met]

(a) Each District agency shall provide cooperation, assistance, data, and the access to records necessary to enable the ombudsman to perform his or her duties under this chapter and other applicable federal and District law. This section shall not be construed to supercede the laws or rules governing access to unexpurgated arrest records maintained by the Metropolitan Police Department or interfere with ongoing criminal investigations.

(b) The ombudsman or his or her designee shall have the same access that is provided to the Mayor to review, inspect, or photocopy the records of a resident of a facility covered by § 44-501 et seq., or § 44-1001.01 et seq., to carry out the provisions of this chapter.

(c) The ombudsman or his or her designee may request a subpoena pursuant to § 1-301.21, to obtain access to records covered by this section.

(d) An owner, employee, or agent of a long-term care facility who lawfully discloses information or permits access to records pursuant to this section shall not be liable for civil penalties or criminal prosecution.

(e) An owner, employee, or agent of a long-term care facility subject to 45 CFR §§ 164.500 through 164.534 (the Health Insurance Portability and Accountability Act privacy regulation), shall release records to the program as an exempt health oversight agency.

HISTORY: 1981 Ed., § 6-3522; Mar. 16, 1989, D.C. Law 7-218, § 302, 36 DCR 534; Mar. 12, 2011, D.C. Law 18-321, § 2(g), 57 DCR 12438.

NOTES: SECTION REFERENCES. --This section is referenced in § 7-702.04 and § 7-704.01.

EFFECT OF AMENDMENTS. --The 2011 amendment by D.C. Law 18-321 added (e).

LEGISLATIVE HISTORY OF LAW 7-218. --See note to § 7-701.01.

LEGISLATIVE HISTORY OF LAW 18-321. --See note to § 7-701.01.

EDITOR'S NOTES. --For text of section applicable upon the inclusion of the fiscal effect of D.C. Law 19-111 in an approved budget and financial plan, see the second version.

LexisNexis 50 State Surveys, Legislation & Regulations

Healthcare Ombudsing



13 of 19 DOCUMENTS

LEXIS DISTRICT OF COLUMBIA CODE ANNOTATED
Copyright 2012 by Matthew Bender & Company, Inc.,
a member of the LexisNexis Group.
All rights reserved.

*** Current through May 30, 2012, and through D.C. Acts 19-375 and 19-377 ***
*** Annotations current through May 1, 2012 ***

DIVISION I. GOVERNMENT OF DISTRICT
TITLE 7. HUMAN HEALTH CARE AND SAFETY
SUBTITLE A. GENERAL
CHAPTER 7. LONG-TERM CARE OMBUDSMAN PROGRAM
SUBCHAPTER III. ACCESS FOR THE LONG-TERM CARE OMBUDSMAN AND DESIGNEES

GO TO DISTRICT OF COLUMBIA CODE ARCHIVE DIRECTORY

D.C. Code § 7-703.02 (2012)

THIS SECTION HAS MORE THAN ONE DOCUMENT WITH VARYING EFFECTIVE DATES.

§ 7-703.02. Access to records [Formerly § 6-3522] [Applicable when contingency met]

(a) Each District agency shall provide cooperation, assistance, data, and the access to records necessary to enable the ombudsman to perform his or her duties under this chapter and other applicable federal and District law. This section shall not be construed to supercede the laws or rules governing access to unexpurgated arrest records maintained by the Metropolitan Police Department or interfere with ongoing criminal investigations.

(b) The ombudsman or his or her designee shall have the same access that is provided to the Mayor to review, inspect, or photocopy the records of a resident of a facility covered by § 44-501 et seq., or § 44-1001.01 et seq., to carry out the provisions of this chapter.

(c) The ombudsman or his or her designee may request a subpoena pursuant to § 1-301.21, to obtain access to records covered by this section.

(d) An owner, employee, or agent of a long-term care facility who lawfully discloses information or permits access to records pursuant to this section shall not be liable for civil penalties or criminal prosecution.

(e) An owner, employee, or agent of a long-term care facility or home care agency subject to 45 CFR §§ 164.500 through 164.534 (the Health Insurance Portability and Accountability Act privacy regulation), shall release records to the program as an exempt health oversight agency.

HISTORY: 1981 Ed., § 6-3522; Mar. 16, 1989, D.C. Law 7-218, § 302, 36 DCR 534; Mar. 12, 2011, D.C. Law 18-321, § 2(g), 57 DCR 12438; Mar. 14, 2012, D.C. Law 19-111, § 2(c), 59 DCR 453.

NOTES: EFFECT OF AMENDMENTS. --The 2012 amendment by D.C. Law 19-111 added "or home care agency" in (e).

LEGISLATIVE HISTORY OF LAW 19-111. --See note to § 7-701.01.

EDITOR'S NOTES. --Section 3 of D.C. Law 19-111 provided that the act shall apply upon the inclusion of its fiscal effect in an approved budget and financial plan.

For text of section applicable until the inclusion of the fiscal effect of D.C. Law 19-111 in an approved budget and financial plan, see the first version.

LexisNexis 50 State Surveys, Legislation & Regulations

Healthcare Ombudsing



14 of 19 DOCUMENTS

LEXIS DISTRICT OF COLUMBIA CODE ANNOTATED

Copyright 2012 by Matthew Bender & Company, Inc.,
a member of the LexisNexis Group.

All rights reserved.

*** Current through May 30, 2012, and through D.C. Acts 19-375 and 19-377 ***

*** Annotations current through May 1, 2012 ***

DIVISION I. GOVERNMENT OF DISTRICT
TITLE 7. HUMAN HEALTH CARE AND SAFETY
SUBTITLE A. GENERAL

CHAPTER 7. LONG-TERM CARE OMBUDSMAN PROGRAM
SUBCHAPTER III. ACCESS FOR THE LONG-TERM CARE OMBUDSMAN AND DESIGNEES

GO TO DISTRICT OF COLUMBIA CODE ARCHIVE DIRECTORY

D.C. Code § 7-703.03 (2012)

§ 7-703.03. Visits to the home of a resident [Applicable when contingency met]

The Ombudsman may communicate and visit with a resident who receives home care services; provided, that the Ombudsman obtains permission from the resident or a representative of the resident to enter the resident's home.

HISTORY: D.C. Law 7-218, § 303, as added Mar. 14, 2012, D.C. Law 19-111, § 2(d), 59 DCR 453.

NOTES: EFFECT OF AMENDMENTS. --The 2012 amendment by D.C. Law 19-111 added this section.

LEGISLATIVE HISTORY OF LAW 19-111. --See note to § 7-701.01.

EDITOR'S NOTES. --Section 3 of D.C. Law 19-111 provided that the act shall apply upon the inclusion of its fiscal effect in an approved budget and financial plan.



15 of 19 DOCUMENTS

LEXIS DISTRICT OF COLUMBIA CODE ANNOTATED

Copyright 2012 by Matthew Bender & Company, Inc.,

a member of the LexisNexis Group.

All rights reserved.

*** Current through May 30, 2012, and through D.C. Acts 19-375 and 19-377 ***

*** Annotations current through May 1, 2012 ***

DIVISION I. GOVERNMENT OF DISTRICT

TITLE 7. HUMAN HEALTH CARE AND SAFETY

SUBTITLE A. GENERAL

CHAPTER 7. LONG-TERM CARE OMBUDSMAN PROGRAM

SUBCHAPTER IV. ENFORCEMENT; PENALTIES; JUDICIAL REVIEW

GO TO DISTRICT OF COLUMBIA CODE ARCHIVE DIRECTORY

D.C. Code § 7-704.01 (2012)

§ 7-704.01. Enforcement; penalties [Formerly § 6-3531]

(a) Civil fines, penalties, or related costs may be imposed against any long-term care facility, owner, executive officer, administrator, employee, or agent, for the violation of any provision of this chapter or any rule issued pursuant to this chapter.

(b) Procedures for adjudication and enforcement and applicable civil fines, penalties, or costs shall be those prescribed for a Class 2 civil infraction, pursuant to Chapter 18 of Title 2.

(c) If the ombudsman or his or her designee knowingly violates § 7-702.06 by releasing a confidential document, record, or other information obtained pursuant to § 7-703.02(b), the ombudsman or his or her designee may be prosecuted for a misdemeanor and, upon conviction, subject to a fine of not more than \$ 1,500, imprisonment for not more than 30 days, or both.

(d) No person shall take discriminatory, disciplinary, or retaliatory action against an employee of a long-term care facility or agency, resident, or resident representative for filing in good faith a complaint with, or providing information to, the ombudsman or his designees. A person who violates this provision, or who aids, abets, invites, compels, or coerces another to do so, shall be guilty of a misdemeanor and, upon conviction, shall be subject to a fine not to exceed \$ 1,000, imprisonment not to exceed 180 days, or both. This subsection shall not infringe upon the rights of an employer to supervise, discipline, or to terminate an employee for other reasons.

(e) A person who knowingly denies access to the ombudsman or his or her designee in violation of subchapter III of this chapter, or aids, abets, invites, compels, or coerces another to do so, shall be guilty of a misdemeanor and, upon conviction, shall be subject to a fine not to exceed \$ 1,000, imprisonment not to exceed 180 days, or both.

HISTORY: 1981 Ed., § 6-3531; Mar. 16, 1989, D.C. Law 7-218, § 401, 36 DCR 534; Mar. 12, 2011, D.C. Law 18-321, § 2(h), 57 DCR 12438.

D.C. Code § 7-704.01

NOTES: EFFECT OF AMENDMENTS. --The 2011 amendment by D.C. Law 18-321 added (d) and (e).

LEGISLATIVE HISTORY OF LAW 7-218. --See note to § 7-701.01.

LEGISLATIVE HISTORY OF LAW 18-321. --See note to § 7-701.01.

EDITOR'S NOTES. --LexisNexis believes the translation in (c) of former § 6-3516 (1981 Ed.) as § 7-702.06 (2001 Ed.) is correct; and that a reference to nonexistent § 7-703.06 in that location would be incorrect.

LexisNexis 50 State Surveys, Legislation & Regulations

Healthcare Ombudsing



16 of 19 DOCUMENTS

LEXIS DISTRICT OF COLUMBIA CODE ANNOTATED

Copyright 2012 by Matthew Bender & Company, Inc.,
a member of the LexisNexis Group.
All rights reserved.

*** Current through May 30, 2012, and through D.C. Acts 19-375 and 19-377 ***
*** Annotations current through May 1, 2012 ***

DIVISION I. GOVERNMENT OF DISTRICT
TITLE 7. HUMAN HEALTH CARE AND SAFETY
SUBTITLE A. GENERAL
CHAPTER 7. LONG-TERM CARE OMBUDSMAN PROGRAM
SUBCHAPTER V. PRIVATE RIGHTS OF ACTION

GO TO DISTRICT OF COLUMBIA CODE ARCHIVE DIRECTORY

D.C. Code § 7-705.01 (2012)

§ 7-705.01. Injunctive relief [Formerly § 6-3541]

A resident, a representative of a resident, the ombudsman, or the Attorney General for the District of Columbia may bring an action in court for a temporary restraining order, preliminary injunction, or permanent injunction to enjoin a long-term care facility from violating a provision of subchapter II or III of this chapter or any rule issued by the Mayor pursuant to this chapter.

HISTORY: 1981 Ed., § 6-3541; Mar. 16, 1989, D.C. Law 7-218, § 501, 36 DCR 534; Mar. 12, 2011, D.C. Law 18-321, § 2(i), 57 DCR 12438.

NOTES: SECTION REFERENCES. --This section is referenced in § 7-705.03.

EFFECT OF AMENDMENTS. --The 2011 amendment by D.C. Law 18-321 substituted "Attorney General for the District of Columbia" for "Corporation Counsel for the District of Columbia."

LEGISLATIVE HISTORY OF LAW 7-218. --See note to § 7-701.01.

LEGISLATIVE HISTORY OF LAW 18-321. --See note to § 7-701.01.

LexisNexis 50 State Surveys, Legislation & Regulations

Healthcare Ombudsing



17 of 19 DOCUMENTS

LEXIS DISTRICT OF COLUMBIA CODE ANNOTATED
Copyright 2012 by Matthew Bender & Company, Inc.,
a member of the LexisNexis Group.
All rights reserved.

*** Current through May 30, 2012, and through D.C. Acts 19-375 and 19-377 ***
*** Annotations current through May 1, 2012 ***

DIVISION I. GOVERNMENT OF DISTRICT
TITLE 7. HUMAN HEALTH CARE AND SAFETY
SUBTITLE A. GENERAL
CHAPTER 7. LONG-TERM CARE OMBUDSMAN PROGRAM
SUBCHAPTER V. PRIVATE RIGHTS OF ACTION

GO TO DISTRICT OF COLUMBIA CODE ARCHIVE DIRECTORY

D.C. Code § 7-705.02 (2012)

§ 7-705.02. Civil action for damages [Formerly § 6-3542]

(a) A resident, a representative of a resident, or the ombudsman, on behalf of a resident, may bring an action in court to recover actual and punitive damages for an injury that results from a violation of subchapter II or III of this chapter, or any rule issued by the Mayor pursuant to this chapter. Upon proof of a violation, the resident shall be awarded 3 times the actual damages or \$ 1000, whichever is greater, and may be awarded punitive damages not to exceed \$ 10,000.

(b) The first \$ 7,000 of a damage award recovered by a resident in an action brought under this section shall be excluded from consideration when determining the eligibility of the resident for Medicaid, the amount of assistance the resident is entitled to under Medicaid, or the assets of the resident that the District may subject to a lien, set-off, or other legal process for the purpose of satisfying indebtedness created by the receipt of Medicaid or other public assistance payments.

HISTORY: 1981 Ed., § 6-3542; Mar. 16, 1989, D.C. Law 7-218, § 502, 36 DCR 534; Mar. 12, 2011, D.C. Law 18-321, § 2(j), 57 DCR 12438.

NOTES: SECTION REFERENCES. --This section is referenced in § 7-705.03.

EFFECT OF AMENDMENTS. --The 2011 amendment by D.C. Law 18-321, in (a), substituted "actual damages or \$1000" for "actual damages or \$100" and "punitive damages not to exceed \$10,000" for "punitive damages of up to \$5,000"; and substituted "\$7,000" for "\$3,000" in (b).

LEGISLATIVE HISTORY OF LAW 7-218. --See note to § 7-701.01.

LEGISLATIVE HISTORY OF LAW 18-321. --See note to § 7-701.01.

LexisNexis 50 State Surveys, Legislation & Regulations

Healthcare Ombudsing



18 of 19 DOCUMENTS

LEXIS DISTRICT OF COLUMBIA CODE ANNOTATED
Copyright 2012 by Matthew Bender & Company, Inc.,
a member of the LexisNexis Group.
All rights reserved.

*** Current through May 30, 2012, and through D.C. Acts 19-375 and 19-377 ***
*** Annotations current through May 1, 2012 ***

DIVISION I. GOVERNMENT OF DISTRICT
TITLE 7. HUMAN HEALTH CARE AND SAFETY
SUBTITLE A. GENERAL
CHAPTER 7. LONG-TERM CARE OMBUDSMAN PROGRAM
SUBCHAPTER V. PRIVATE RIGHTS OF ACTION

GO TO DISTRICT OF COLUMBIA CODE ARCHIVE DIRECTORY

D.C. Code § 7-705.03 (2012)

§ 7-705.03. Court costs and attorney's fees [Formerly § 6-3543]

The court shall award costs and reasonable attorney's fees to a resident who prevails in an action brought under § 7-705.01 or § 7-705.02.

HISTORY: 1981 Ed., § 6-3543; Mar. 16, 1989, D.C. Law 7-218, § 503, 36 DCR 534.

NOTES: LEGISLATIVE HISTORY OF LAW 7-218. --See note to § 7-701.01.

LexisNexis 50 State Surveys, Legislation & Regulations

Healthcare Ombudsing



19 of 19 DOCUMENTS

LEXIS DISTRICT OF COLUMBIA CODE ANNOTATED

Copyright 2012 by Matthew Bender & Company, Inc.,

a member of the LexisNexis Group.

All rights reserved.

*** Current through May 30, 2012, and through D.C. Acts 19-375 and 19-377 ***

*** Annotations current through May 1, 2012 ***

DIVISION I. GOVERNMENT OF DISTRICT

TITLE 7. HUMAN HEALTH CARE AND SAFETY

SUBTITLE A. GENERAL

CHAPTER 7. LONG-TERM CARE OMBUDSMAN PROGRAM

SUBCHAPTER VI. MISCELLANEOUS

GO TO DISTRICT OF COLUMBIA CODE ARCHIVE DIRECTORY

D.C. Code § 7-706.01 (2012)

§ 7-706.01. Rules [Formerly § 6-3551]

Within 90 days of March 16, 1989, the Mayor shall, pursuant to subchapter I of Chapter 5 of Title 2, issue proposed rules to implement the provisions of this subchapter. The proposed rules shall be submitted to the Council for a 45-day period of review, excluding Saturdays, Sundays, legal holidays, and days of Council recess. If the Council does not approve or disapprove the proposed rules, in whole or in part, by resolution within this 45-day review period, the proposed rules shall be deemed approved.

HISTORY: 1981 Ed., § 6-3551; Mar. 16, 1989, D.C. Law 7-218, § 601, 36 DCR 534.

NOTES: LEGISLATIVE HISTORY OF LAW 7-218. --See note to § 7-701.01.

LexisNexis 50 State Surveys, Legislation & Regulations

Healthcare Ombudsing

Attachment H:

Ombudsman Code of Ethics

Code of Ethics for Long Term Care Ombudsmen

The National Association of State Long Term Care Ombudsman Programs

1. The ombudsman provides services with respect for human dignity and the individuality of the client², unrestricted by considerations of age, social or economic status, personal characteristics, or lifestyle choices.
2. The ombudsman respects and promotes the client's right to self-determination
3. The ombudsman makes every reasonable effort to ascertain and act in accordance with the client's wishes.
4. The ombudsman acts to protect vulnerable individuals from abuse and neglect.
5. The ombudsman safeguards the client's right to privacy by protecting confidential information.
6. The ombudsman remains knowledgeable in areas relevant to the long term care system, especially regulatory and legislative information, and long term care service options.
7. The ombudsman acts in accordance with the standards and practices of the Long Term Care Ombudsman Program, and with respect for the policies of the sponsoring organization.
8. The ombudsman will provide professional advocacy services unrestricted by his/her personal belief or opinion.
9. The ombudsman participates in efforts to promote a quality, long term care system.
10. The ombudsman participates in efforts to maintain and promote the integrity of the Long Term Care Ombudsman Program.
11. The ombudsman supports a strict conflict of interest standard that prohibits any financial interest in the delivery or provision of nursing home, board and care services, or other long term care services that are within their scope of involvement.
12. The ombudsman shall conduct himself/herself in a manner that will strengthen the statewide and national ombudsman network.

² In the Code of Ethics, *client* refers to the range of consumers served by LTCO such as residents, their families members, and individuals who are seeking information about long-term care facilities.

Office of the DC Long-Term Care Ombudsman

Legal Counsel for the Elderly

601 E Street, NW

Washington, DC 20049

(202) 434-2190 (Office)

(202) 434-6595 (Fax)

www.aarp.org/lce