



The National Long-Term Care
Ombudsman Resource Center

MODULE FOUR

Long-Term Care Settings,
Residents' Rights, and
Enforcement

TRAINEE MANUAL

January 2025

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Section 1:

Welcome and Introduction

Welcome

Welcome to Module 4 of certification training ***Long-Term Care Settings, Residents' Rights, and Enforcement***. Thank you for being here to learn more about the Long-Term Care Ombudsman program and the certification process.

Module 4 Agenda

- Section 1: Welcome and Introduction
- Section 2: Long-Term Care Settings
- Section 3: Who's Who in Long-Term Care Facilities
- Section 4: Residents' Rights in Nursing Facilities
- Section 5: Regulatory Process for Nursing Facilities
- Section 6: Residents' Rights in Residential Care Communities and the Regulatory Process
- Section 7: Conclusion

Module 4 Learning Objectives

By the end of this Module, you will understand the following:

- The different types of long-term care settings, including home and community-based services
- The various staff positions in nursing facilities and residential care communities (RCCs)
- Residents' rights in long-term care facilities and how the Ombudsman program can help when those rights are violated
- Residents' rights in residential care communities
- The regulatory process for both nursing facilities and RCCs

Module 4 Key Words and Terms

The key words and terms are defined relative to Ombudsman program practices and are found throughout this Module. Take a moment to familiarize yourself with this important information.

Centers for Medicare & Medicaid Services (CMS) – A division within the U.S. Department of Health and Human Services, CMS administers the nation's major healthcare programs including Medicare and Medicaid.

Critical Access Hospital (CAH) – A rural hospital certified by Centers for Medicaid & Medicare Services (CMS) as a CAH with beds (known as "swing beds") may use the

swing beds to provide skilled nursing facility (SNF) care. CAHs must follow the federal nursing facilities regulations for all certified beds.¹

Empowerment – A core approach of the Long-Term Care Ombudsman program in which representatives provide the tools (e.g., information about residents' rights, facility responsibilities), encouragement, and assistance to promote resident self-advocacy.

Highest Practicable Level of Well-Being – The highest possible level of physical, mental, and psychosocial functioning a resident can maintain or achieve.

Hospice – An agency or organization that provides care to terminally ill individuals and has a valid Medicare provider agreement. Some hospices are located within a hospital, nursing facility, or a home health agency.²

Informed Consent – The permission from a resident or a resident representative after an explanation has been given of the facts, options, and possible outcomes of such options in a manner and language in which the resident or resident representative understands.

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) – The ICF/IID benefit is an optional Medicaid benefit; however, all states offer this. ICF/IID provide active treatment for individuals with intellectual disabilities and other related conditions. Residents in ICF/IID may be non-ambulatory, have seizure disorders, mental illness, visual or hearing problems, or a combination of conditions. Currently, the Ombudsman program in very few states either visit or respond to complaints from ICF/IID.³

Medicaid – A state and federal assistance program that serves low-income people of every age. It is run by state and local governments following federal guidelines.⁴

Medicare – A federal insurance program run by CMS for those who have paid into the program. It serves people over 65 years of age, regardless of their income; younger individuals with disabilities; and persons on dialysis.⁵

Minimum Data Set 3.0 (MDS, MDS 3.0) – A federally mandated assessment of all residents in Medicare and Medicaid certified nursing facilities. MDS assessments are conducted upon admission, throughout the resident's stay and upon discharge. The data from the assessments is transmitted electronically using the MDS national database at CMS.⁶

¹ <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/CAHs>

² <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Hospices>

³ <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/ICFIID>

⁴ <https://www.hhs.gov/answers/medicare-and-medicaid/what-is-the-difference-between-medicare-medicaid/index.html>

⁵ <http://www.medicare.gov>

⁶ Centers for Medicare & Medicaid Services retrieved from <https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Minimum-Data-Set-3-0-Public-Reports>

Office of the State Long-Term Care Ombudsman (Office, OSLTCO) – As used in sections 711 and 712 of the Act, means the organizational unit in a State or territory which is headed by a State Long-Term Care Ombudsman.⁷

Ombudsman – A Swedish word meaning agent, representative, or someone who speaks on behalf of another. For the purposes of this manual, the word “Ombudsman” means the State Long-Term Care Ombudsman.

Representatives of the Office of the Long-Term Care Ombudsman

(Representatives) – As used in sections 711 and 712 of the Act, means the employees or volunteers designated by the Ombudsman to fulfill the duties set forth in §1324.19(a), whether personnel supervision is provided by the Ombudsman or his or her designees or by an agency hosting a local Ombudsman entity designated by the Ombudsman pursuant to section 712(a)(5) of the Act.⁸

Resident Representative – An individual chosen by the resident to act on their behalf, or a person authorized by federal or state law (e.g., agent under a Power of Attorney, representative payee, and other fiduciaries) to act on behalf of a resident in order to support the resident in decision-making; accessing medical, social, or other personal information of the resident; managing financial matters; or receiving notifications; legal representative (as used in Section 712 of the Act), or a court-appointed guardian or conservator of a resident.⁹

Residential Care Community (RCC) – A type of long-term care facility as described in the Older Americans Act (Act) that, regardless of setting, provides at a minimum, room and board, around-the-clock on-site supervision, and help with personal care such as bathing and dressing or health-related services such as medication management. Facility types include but are not limited to, assisted living; board and care homes; congregate care; enriched housing programs; homes for the aged; personal care homes; adult foster/ family homes and shared housing establishments that are licensed, registered, listed, certified, or otherwise regulated by a state.¹⁰

Social Security Administration (SSA) – A government agency that administers Social Security, a social insurance program with retirement, disability, and survivor benefits.¹¹

Skilled Nursing Facility or Nursing Facility – Also known as a “nursing home,” is a certified facility that provides skilled nursing care for residents who require medical or nursing care rehabilitation or provides health-related care and services to individuals

⁷ 45 CFR Part 1324 Subpart A §1324.1 Definitions

⁸ 45 CFR Part 1324 Subpart A §1324.1 Definitions

⁹ LTCOP Final Rule §1324.1 Definitions <https://www.govinfo.gov/content/pkg/CFR-2017-title45-vol4/xml/CFR-2017-title45-vol4-part1324.xml>

¹⁰ CA-04 02 Residential Care Community Table 1 Part C Case and Complaint Definitions https://ltombudsman.org/uploads/files/support/NORS_Table_1_Case_Level_10-31-2024.pdf

¹¹ Social Security Administration <https://www.ssa.gov/>

who, because of their mental or physical condition, require care and services (above the level of room and board) which can be made available to them only through institutional facilities.¹² For the purposes of this training and to be consistent with the National Ombudsman Reporting System (NORS), we use the term “nursing facility” for both skilled nursing facilities and nursing facilities.¹³

State Long-Term Care Ombudsman (Ombudsman, State Ombudsman) – As used in sections 711 and 712 of the Act, means the individual who heads the Office and is responsible personally, or through representatives of the Office, to fulfill the functions, responsibilities and duties set forth in §1324.13 and §1324.19.

State Long-Term Care Ombudsman Program (Ombudsman program, the program, LTCOP) – As used in sections 711 and 712 of the Act, means the program through which the functions and duties of the Office are carried out, consisting of the Ombudsman, the Office headed by the Ombudsman, and the representatives of the Office.¹⁴

State Survey Agency – The state agency responsible for certifying and/or licensing long-term care facilities and conducting inspections and investigations to ensure federal and state compliance.

State Surveyor – An individual who works for the state survey agency and conducts in-depth surveys, inspections, and investigations of long-term care facilities.

Subsection symbol (§) – The subsection symbol is used to denote an individual numeric statute or regulation (rule).

¹² This definition is a combination of Requirements for, and assuring Quality of Care in, Skilled Nursing Facilities, Section 1819(a) of the Social Security Act [42 U.S.C. 1395i–3(a)] https://www.ssa.gov/OP_Home/ssact/title18/1819.htm and Requirements for Nursing Facilities, Section 1919(a) of the Social Security Act [42 U.S.C. 1396r(a)] https://www.ssa.gov/OP_Home/ssact/title19/1919.htm

¹³ NORS Table 1 https://tcombudsman.org/uploads/files/support/NORS_Table_1_Case_Level_10-31-2024.pdf

¹⁴ 45 CFR Part 1324 Subpart A §1324.1 Definitions

Section 2:

Long-Term Care Settings

Long-Term Services and Supports

“Long-term services and supports” describes a range of services for older adults and people with disabilities. Services and supports are provided to help people live as independently as possible by assisting with healthcare needs and activities of daily living. Examples of supports include assistance with meals, bathing, grooming, dressing, managing medication, managing money, walking, and providing medical care. Care and services are provided in a variety of settings such as individuals’ homes, community-based settings, residential care communities, and nursing facilities.

Long-term care facilities (residential care communities and nursing facilities) provide a variety of supports and services. The supports and services depend upon the facility’s certification and/or license. It is important to get to know the structure and the supports and services of the facilities that you visit.

Paying for Long-Term Services and Supports

There are a variety of ways in which services and supports are paid for or supplemented. Some individuals pay “out of pocket” and others rely on government payer sources to cover all or most of their care.

Resident Funds

“Private pay” is a term used to describe payment when a resident does not use state or federal assistance to pay for long-term services and supports. Private pay could include using the resident’s income, such as Social Security, pensions, other funds, and/or insurance (e.g., supplemental insurance, life insurance policies, long-term care insurance). Insurance policies, including long-term care insurance, vary in coverage of services.

Veterans’ Assistance

Veterans may be eligible for services through federal or state Veterans Affairs (VA) benefits. Some veterans can receive nursing and medical care, physical therapy, help with activities of daily living (ADLs), pain management, etc. These services can be provided in various settings such as residential care communities (RCCs), nursing facilities, adult day centers, and at home.

GOVERNMENT PAYER SOURCES

The introductory information for these government payer sources is specific to long-term services and supports. For example, Medicaid provides health coverage to millions of Americans, including eligible low-income individuals, children, and pregnant women, but, for the purposes of this training, we are only discussing Medicaid coverage for long-term services and supports.



Learn more about federal VA benefits [here](#).¹⁵

¹⁵ U.S. Department of Veterans Affairs <https://www.va.gov/health-care/about-va-health-benefits/long-term-care/>

Medicare and Medicaid

Medicare and Medicaid are both public insurance programs that help cover the cost of medical care. Many people in nursing facilities rely on these programs to help cover a portion of their stay. However, residents and family members often confuse the two programs.

Medicare	Medicaid
Federal funds	Combination of state and federal funds
Administered by Centers for Medicare & Medicaid Services (CMS)	Administered by CMS and the state
65 years of age and older or age 64 and younger with certain disabilities or illnesses	No age requirement
Individual has worked and paid Medicare taxes and/or pays a Medicare premium	Income requirements for eligibility
Limited long-term care coverage	Covers room and board and the cost of supports and services
Skilled nursing care benefit period up to 100 days	Benefits are long-term

Medicare¹⁶

Medicare is a health insurance program for people who are 65 years of age or older, or age 64 and younger with certain disabilities or illnesses. It helps with the cost of health care, but it does not cover all medical expenses or the cost of most long-term care. Medicare covers *skilled care*¹⁷ in a nursing facility when the individual has a qualifying three-day stay in a hospital and meets all other criteria. Medicare benefits may be paid toward skilled care for up to 100 days (Medicare pays approximately 80% of the cost of skilled care for days 21-100).

Medicare Part A (hospital insurance) helps pay for inpatient care in a hospital or limited time at a skilled nursing facility (following a hospital stay). Part A also pays for some home health care and hospice care.

Medicare Part B (medical insurance) helps pay for services from doctors and other health care providers, outpatient care, home health care, durable medical equipment, and some preventive services.

Other parts of Medicare are run by private insurance companies that follow rules set by Medicare.

¹⁶ Social Security Administration *Medicare Benefits* <https://www.ssa.gov/benefits/medicare/>

¹⁷ Medicare Skilled nursing facility (SNF) care <https://www.medicare.gov/coverage/skilled-nursing-facility-snf-care>

Medicare coverage depends upon the resident's care needs as well as their Medicare Plan and may include, but is not limited to:

- Home health care
- Care in a skilled nursing facility after a 3-day hospital stay
- Certain prescription drugs
- Skilled rehabilitation (therapy) either inpatient or at home
- Hospice services

Skilled Care Definition

Skilled Care is nursing and therapy care that can only be safely and effectively performed by, or under the supervision of, professionals or technical personnel.

Medicaid

Medicaid is the most common payer source for nursing facility residents. Medicaid eligibility requirements for nursing facility care are based on income and level of care, determined by each state.

Medicaid covers room and board as well as the cost of supports and services in certified nursing facilities after the resident's income sources and insurance have been exhausted. When a resident has their care covered by Medicaid, they are only allowed a set amount of money (that varies from state to state) considered as their personal spending money. This is called the "Personal Needs Allowance."

Medical services provided under Medicaid include, but are not limited to:

- Occupational therapy
- Physical therapy
- Prescribed drugs and other medications
- Eyeglasses
- Transportation
- Medical equipment and supplies
- Medication

There are limitations on the services and equipment provided by Medicaid. For example, Medicaid may limit the number of pairs of glasses it will purchase. This can be a problem when glasses are often lost or broken.



Learn more about Medicare [here](https://www.medicare.gov/).¹⁸ Learn more about Medicaid [here](https://www.medicare.gov/).¹⁹

¹⁸ Medicare <https://www.medicare.gov/>

¹⁹ Medicaid <https://www.medicare.gov/>

Medicaid Home and Community-Based Services (HCBS) Waiver Programs

Home and Community-Based Services (HCBS) are a Medicaid state plan option that allows states to provide services to individuals eligible for Medicaid in their own home or a community-based setting (including some residential care communities), instead of an “institutional” setting such as a nursing facility. States provide services under Medicaid waivers according to provisions in Section 1915(c) of the Social Security Act. These services are determined through person-centered planning. Several states include HCBS services in their Medicaid State plans. As of 2021, 47 states and Washington, D.C. are operating at least one 1915(c) waiver. Payment for these services are a combination of federal and state funds and some contribution from the individual receiving services.

Long-Term Care Services

Skilled Nursing Facility or Nursing Facility (SNF/NF)

Skilled nursing facilities or nursing facilities are certified facilities that provide skilled nursing care for residents who require medical or nursing care rehabilitation. SNF/NF also provide health care and services to individuals who, because of their mental or physical condition, require care and services (above the level of room and board) which can be made available to them only through institutional facilities.

Nursing facilities must be licensed by individual states and certified as a nursing facility, skilled nursing facility, or both, to participate in Medicare and Medicaid. Medicare and Medicaid are the primary payment sources for most residents in nursing facilities.

Federal law and regulation govern skilled nursing/nursing facilities. State law and regulation govern the few nursing facilities that do not accept federal funds and do not operate under a Medicare/Medicaid contract.

Most nursing facilities are “dually certified” for Medicare and Medicaid, meaning that if qualified, a resident’s stay is partially paid for by either government program. Federal certification is further discussed in Section 5.

Dually certified beds offer more flexibility for a resident to stay in that room/bed if their Medicare days are over and they apply for Medicaid to continue their coverage. The resident cannot be forced to leave that bed just because of their payment source.

Distinct Part Definition

Skilled nursing facilities with a separate area of beds that are certified as either Medicare or Medicaid, but not both, or, have beds in a specific area that are physically separated and certified for Medicare only, are called “distinct part.”

Skilled Care

Skilled care is usually short-term and can only be performed by skilled or licensed professionals such as a registered nurse or a physical therapist.

Examples of skilled care include but are not limited to:

- Physical therapy
- Wound care
- Speech therapy
- IV medication

Residents may have a short stay in a skilled nursing facility as part of their Medicare benefit; typically, this is for specialized nursing or rehabilitation services.

Long-Term Care

Some people may stay in a nursing facility long-term because they have continuous care needs that may require both skilled care and assistance with activities of daily living, such as bathing, grooming, assistance with walking and exercise, and medication management.

Nursing facilities are to follow the same set of regulations and offered skilled services for both short- and long- term stays.

Residential Care Community (RCC)

An RCC is a type of long-term care facility as described in the Older Americans Act that, regardless of setting, provides at a minimum: room and board, around-the-clock on-site supervision, and help with personal care such as bathing and dressing or health-related services such as medication management.

Facility types include but are not limited to: assisted living; board and care homes; congregate care; enriched housing programs; homes for the aged; personal care homes; adult foster/ family homes; and shared housing establishments that are licensed, registered, listed, certified, or otherwise regulated by the state.

Services offered by RCCs vary by state law and regulation. Residents may receive skilled nursing or rehabilitation services in these settings from an outside provider (e.g., home health).

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)²⁰

ICF/IID provide active treatment (AT) for individuals with intellectual disabilities and other related conditions.²¹

Intermediate Care Facilities for Individuals with Intellectual disability (ICF/IID) is an optional Medicaid benefit that enables states to provide comprehensive and individualized health care and rehabilitation services to individuals to promote their functional status and independence. Although it is an optional benefit, all states offer it, if only as an alternative to home and community-based services waivers for individuals at the ICF/IID level of care.

ICF/IID is available only for individuals in need of, and receiving, active treatment (AT) services. AT refers to aggressive, consistent implementation of a program of specialized and generic training, treatment, and health services. AT does not include services to maintain generally independent clients who are able to function with little supervision and who do not require a continuous program of habilitation services. States may not limit access to ICF/IID service, or make it subject to waiting lists, as they may for Home and Community Based Services (HCBS). Therefore, in some cases ICF/IID services may be more immediately available than other long-term care options. Many individuals who require this level of service have already established disability status and Medicaid eligibility.

Need for ICF/IID is specifically defined by states, all of whom have established ICF/IID level of care criteria. State level of care requirements must provide access to individuals who meet the coverage criteria defined in federal law and regulation. In addition to level of care for AT, the need for AT must arise from an intellectual disability or a related condition.

Many ICF/IID residents work in the community with supports or participate in vocational or other activities outside of the residence and engage in community interests of their choice. These activities are collectively often referred to as day programs. The ICF/IID is responsible for all activities, including day programs, because the concept of AT is that all aspects of support and service to the individual are coordinated towards specific individualized goals in the individual performance plan (IPP).

²⁰ Most of the information in this section was adapted from the Centers for Medicare & Medicaid Services (CMS) Medicaid.gov Intermediate Care Facilities for Individuals with Intellectual Disability <https://www.medicaid.gov/medicaid/long-term-services-supports/institutional-long-term-care/intermediate-care-facilities-individuals-intellectual-disability/index.html>

²¹ 42 CFR Subpart I -Conditions of Participation for Intermediate Care Facilities for Individuals with Intellectual Disabilities <https://www.law.cornell.edu/cfr/text/42/part-483/subpart-1>



Learn more about Intermediate Care Facilities for Individuals with Intellectual Disability ([ICF/IID](#)).²²

Critical Access Hospital (CAH)

A rural hospital certified by Centers for Medicaid & Medicare Services (CMS) as a CAH with beds (known as “swing beds”) may use the swing beds to provide skilled nursing facility (SNF) care. CAHs must follow the federal nursing facilities regulations for all certified beds.

Continuing Care Retirement Communities (CCRC)

Sometimes CCRCs are called continuing care communities, life care communities, or other variations. CCRCs are usually on a campus and provide accommodations for independent living, residential care communities, and nursing facility care. Each individual care setting must meet state and federal requirements, when applicable.

Other Services that may be Provided in a Long-Term Care Facility

Home Health Services

Home health services provide a range of health care services in individuals’ homes, hospice facilities, residential care communities, and nursing facilities. Medicare, Medicaid, and other insurance may reimburse home health providers for services for eligible individuals.



Learn more about home health services [here](#).²³

Palliative Care and Hospice Care²⁴

Both palliative care and hospice care provide comfort. Palliative care can begin at diagnosis and at the same time as treatment, whereas hospice care begins after treatment of the disease is stopped and when it is clear that the person is not going to survive the illness.²⁵

Palliative care is a resource for anyone living with a serious and/or chronic illness. Palliative care teams work with the resident and others to provide coordinated medical, social, and emotional support. The team is made of

²² Intermediate Care Facilities for Individuals with Intellectual Disability <https://www.medicaid.gov/medicaid/long-term-services-supports/institutional-long-term-care/intermediate-care-facilities-individuals-intellectual-disability/index.html>

²³ Medicare Home health services <https://www.medicare.gov/coverage/home-health-services>

²⁴ <https://www.nia.nih.gov/health/what-are-palliative-care-and-hospice-care>

²⁵ <https://medlineplus.gov/ency/patientinstructions/000536.htm>

palliative care specialist doctors and nurses, and includes others such as social workers, nutritionists, and chaplains.

Hospice care is for terminally ill individuals whose doctors believe have six or fewer months to live if the illness runs its natural course. Hospice provides comfort care to the resident as well as support for the family. Once a person decides to receive hospice services, attempts to cure the illness are stopped.



Learn more about hospice and palliative care click [here](#).²⁶

Home and Community-Based Services

Home and community-based services (HCBS) provide opportunities for individuals eligible for Medicaid to receive services in their own home or community rather than an institution (e.g., long-term care facility) or other isolated setting. These programs serve a variety of individuals, including people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses.²⁷

All LTCOPs provide information and assistance regarding long-term services and supports, but only a few programs provide services to individuals receiving home and community-based services. Those Ombudsman services should have funding separate from the Older Americans Act. However, to support independence, the Older Americans Act does allow for Ombudsman programs to advocate for residents transitioning to a home care setting. Follow your state policies and procedures.

²⁶ U.S. Department of Health & Human Services National Institute on Aging <https://www.nia.nih.gov/health/what-are-palliative-care-and-hospice-care>

²⁷ <https://www.medicaid.gov/medicaid/home-community-based-services/index.html>

Section 3:

Who's Who in Long-Term Care Facilities

Long-term care facilities are owned and operated by different entities. They may be non-profit or for profit and may be run as a single facility or be part of a state or national corporation. The owner or governing body of a facility has the overall responsibility for the operation of the facility, including budgetary decisions and the development of policies and procedures, and assuring compliance with all federal and state requirements. When resolving facility-wide complaints, it is helpful for the LTCOP to learn which party is best suited to resolve the concern.

During your visits to the facility, you will get to know staff and the role that they play. You may find that some are more responsive than others in resolving resident complaints. Through experience you will learn the responsibilities of each staff member and their willingness to assist, so you can identify who will best be able to address the resident's concern.

Each residential care community is unique. The organizational structure differs from one to another, and each may use different terms or titles when referring to the employees. Depending on size, a small facility may operate with a manager and attendants, caregiver, or aides, while a large facility may have a variety of departments with multiple staff.

The following are key staff members in nursing facilities. RCCs may or may not have similar positions but an asterisk (*) below indicates common RCC terminology.

Administrator (*Manager, Director, Operator, etc.)

The administrator operates and manages the nursing facility and is responsible for supervising the work of all employees. The administrator is also responsible for ensuring the facility meets federal and state requirements.

Director of Nursing (DON)

The DON is responsible for ensuring the nursing care provided by other nurses and nursing aides meets federal and state requirements.

Assistant Director of Nursing (ADON)

Not all nursing facilities have an ADON. The ADON helps the DON with their duties.

Charge Nurse

The charge nurse is a registered nurse (RN) or a licensed practical nurse (LPN) who supervises nursing care during a given shift. Depending on the size of the facility, there may be more than one charge nurse.

Certified Nursing Assistant (CNA)

CNAs provide the personal care residents receive each day. CNAs assist residents with activities of daily living and often spend more time with the residents than anyone else that works in the facility.

***Non-Certified Attendant, Assistant, or Caregiver**

Individuals working in an RCC who perform various functions but are not required to be licensed or certified.

MDS Coordinator

The MDS coordinator is often the Medicare coverage expert responsible for coding the Minimum Data Set (MDS) resident assessments. MDS coordinators are typically RNs who may serve in a variety of roles in the nursing facility.

Care Plan Coordinator

The care plan coordinator is a nurse who works with other facility staff, residents, and residents' family members to conduct assessments and to coordinate individual nursing care. The care plan coordinator is responsible for writing care plans and conducting care plan meetings.

Social Worker or Social Services Director

The facility social worker provides services to assist with the well-being of residents and acts as a liaison between residents and/or family members and facility staff. Facility social workers are typically familiar with resources within the community and may be involved with the discharge process or assisting a resident with accessing services inside and outside of the facility.

Activities Director

The activities director plans and implements an activity program designed to meet the individual needs of the residents. Scheduled activities may be large or small group activities or may even be one-on-one.

Dietary Manager or Director of Food Services

The dietary manager is responsible for the receipt and storage of food supplies and provides oversight for meal preparation to meet the individual dietary needs of each resident. Some larger facilities have a corporate dietitian who is responsible for meeting the dietary needs of residents in several facilities and may develop a set menu for the dietary manager to follow. Other dietary staff include cooks and servers.

Physical, Speech, and Occupational Therapists

These therapists may work for an outside agency that contracts with the facility, which means the therapists may not be actual employees of the facility. **Physical therapists** assist residents with restoring their physical mobility and function following a serious injury or illness. **Speech therapists** assist residents who have problems with verbal communication as well as problems with swallowing. **Occupational therapists** assist residents with regaining their ability to perform activities of daily living (e.g., eating, dressing, grooming).

Laundry Supervisor

The laundry supervisor is responsible for managing the residents' laundry.

Housekeeping Manager or Director of Housekeeping

The housekeeping manager is responsible for ensuring the entire facility, including resident rooms, are clean and orderly. The housekeeping manager is responsible for the housekeeping staff who clean the facility.

Maintenance Supervisor

The maintenance supervisor is responsible for maintaining the facility’s building, equipment, and grounds.

Business Office Manager

The business office manager is responsible for overseeing the financial operations of the facility, which includes billing and keeping track of any resident funds held by the facility.

Admissions Coordinator

The admissions coordinator is likely the first person a resident or family member meets. The admissions coordinator works with other facility staff to determine the capacity of the facility to accept new residents.

Medical Director

The medical director is a physician who assists in the development and implementation of policies and procedures related to the health and care of residents. The medical director may serve as a consultant to the resident’s physician or may be the resident’s physician or may oversee a nurse practitioner.

Pharmacist Consultant

While not an employee in most facilities, a pharmacist consultant is a person who establishes, evaluates, and coordinates all aspects of pharmaceutical services provided to all residents within a facility by all providers (e.g., pharmacy, prescription drug plan, prescribers). They can initiate conversations with facility staff that may lead to medication changes.

Other personnel in the facility may include a receptionist, medical records staff, and a religious figure.



Activity: Who would you go to?

Match the staff member who may be best to speak with about the concern. Some concerns may involve one or more staff member.

Concern	Staff
Question about a resident’s bill	Administrator or Manager
Call lights aren’t being answered	DON
Residents are bored	Charge nurse
Cold food	Maintenance supervisor
Sticky floors	Activities director
Poor staff attitudes towards residents	Housekeeping manager
Broken sink	CNA
Soiled laundry in the resident’s room	Business office manager
Not included on shopping trips	Social service director
CNAs waking residents at 4:00 a.m.	Dietary manager

Nursing Facility Staffing Requirements

The LTCOP often receives complaints about “lack of staff.” Federal nursing facilities regulations do not require a specific number of staff per residents (i.e., resident to staff ratio); however, some state regulations do.

Federal nursing facility staffing requirements:

- at least 1 RN on duty no less than 8 hours per day, 7 days per week;
- the DON may serve as the 1 RN on duty if the facility has fewer than 60 beds;
- a licensed nurse on duty for evening and night shifts; and
- a sufficient level of additional staff, including CNAs.

What do the federal regulations say about training or skill requirements?

Nursing Staff: The facility must have sufficient nursing staff with the appropriate knowledge and skill sets to provide nursing and related services to assure resident safety and 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 and considering the number, acuity, and diagnoses of the facility’s resident population in accordance with the facility assessment requirements.

Licensed Nurses: The facility must ensure that licensed nurses have the competencies and skill sets necessary to care for residents’ needs, as identified through resident assessments, and described in the plan of care.

Certified Nursing Aides: The facility must ensure that CNAs 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.

Section 4:

Residents' Rights in Nursing Facilities

Introduction to Residents' Rights and the Role of the Ombudsman Program

Understanding residents' rights is essential as the Ombudsman program is responsible for sharing information about residents' rights and supporting residents in exercising their rights. This section provides an overview of residents' rights and the role of the LTCOP.

Ombudsman Program Role

The role of the Ombudsman program is to educate individuals on residents' rights and to advocate that those rights are honored and respected.

The Ombudsman program can play an important role in helping people restore their sense of self and regain their personal power and voice.

For example, if a resident:

- Is comfortable speaking up to address concerns, a representative can provide information and reassure them of their rights
- Wants more support, a representative can be present as the resident expresses their needs and preferences or speak on the resident's behalf
- Is unable to communicate their needs and preferences, a representative may work with the resident representative to address a concern

The first step is to get to know residents as individuals. It is important to relate honestly and authentically to the resident and their situation. After establishing a meaningful connection with a resident, they may share their experiences and concerns with you. How you respond and work with these concerns can go a long way in empowering residents and restoring their sense of self.

The Ombudsman program role, process, and approach are generally the same whether a resident resides in a nursing facility, residential care community, or other setting. Charts found in this section under "Ombudsman Program Advocacy Examples" share potential approaches to address residents' rights violations.

It is important for representatives to understand residents' rights, laws, and regulations to use them as advocacy tools. However, it is the role of the state survey agency (surveyors) to enforce regulations, not the Ombudsman program.

Laws and regulations for long-term care settings vary. This section references federal laws and regulations that are applicable only to nursing facilities (NFs) that accept Medicaid or Medicare. There are no comparable federal laws or regulations for residential care communities (RCCs). Refer to state laws and regulations for residential

care communities and nursing facilities that do not accept Medicaid or Medicare. Although laws and regulations vary, most of the Ombudsman program advocacy examples in the charts below apply regardless of setting.

Nursing Facility Residents' Rights

All United States citizens have rights set forth by the Constitution of the United States. Individuals do not lose these rights when they become a resident of a long-term care facility. In fact, they are guaranteed additional rights under federal laws specific to their status as residents. The current federal law pertaining to residents' rights is **42 U.S. Code of Federal Regulations Part 483 *Requirements for States and Long-Term Care Facilities* (Federal Nursing Facilities Regulations)**.²⁸

Federal Nursing Facilities Regulations

The federal nursing facilities regulations clarify required actions and responsibilities of nursing facilities. In addition, the regulations specifically describe each right an individual has as a resident of a nursing facility.

The state survey agency, sometimes referred to as “the state,” is responsible for certifying and/or licensing long-term care facilities and conducting inspections and investigations to ensure federal and state compliance.

A state surveyor is someone who works for the state survey agency to conduct in-depth surveys, inspections, and investigations of long-term care facilities.

Residents' Rights in Federal Nursing Facilities

Regulations

The following is a summary of residents' rights as spelled out in the federal nursing facilities regulations, specifically, *§483.10 resident rights* and *§483.12 freedom from abuse, neglect, and exploitation* and *§483.15 admission, transfer, and discharge rights*. Following the summary, the charts show examples of rights violations and how the Ombudsman program (LTCOP) can begin to address these residents' rights violations.

Note: For purposes of this training, the advocacy examples are intended to be simple and are not inclusive of all resolution strategies. Assume all necessary permission has been granted by the resident or the resident's representative for the Ombudsman program to proceed with the advocacy examples in the chart.

²⁸42 CFR Part 483 Requirements for States and Long-Term Care Facilities retrieved from: <https://www.govinfo.gov/content/pkg/FR-2016-10-04/pdf/2016-23503.pdf>



Learn more about residents’ rights [here](#)²⁹ by watching a video that can be viewed for additional information or used as a presentation for facility staff, consumer groups, or community education.

Residents’ 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:

- Treat each resident with dignity and respect
- Care for each resident in a manner that promotes quality of life
- Recognize each resident’s individuality
- Protect and promote the rights of the resident
- Provide equal access to care

Exercise of rights

The resident has a right to exercise their rights as a resident and as a citizen of the United States.

A facility must:

- Ensure the resident can exercise rights without interference, coercion, discrimination, or reprisal
- Support the resident in exercising their rights

These initial regulations are the foundation for residents’ rights requirements. Each resident has the right to be treated with dignity and respect. To do so, staff must focus on assisting the resident in maintaining and enhancing their self-esteem and self-worth and including the resident’s goals, preferences, and choices. When providing care and services, staff must respect each resident’s individuality, as well as honor and value their input.

Rights Violations	Ombudsman Program Advocacy Examples
Staff do not knock or obtain permission before entering a resident’s room.	Talk to facility staff about respecting the resident’s personal space. Offer to conduct a staff in-service training on dignity and respect.
A staff member stands over Mary when they assist her with eating and refer to her as a “feeder.”	Talk to the supervisor about the use of the word “feeder” or any other disrespectful term used to describe a resident. Also

²⁹ National Long-Term Care Resource Center *Residents’ Rights* <https://youtu.be/34Z0LYhLtl8>

	discuss the demeaning practice of standing over Mary to help her eat. Offer to provide training to staff on dignity and respect.
Susan's mail is being opened by the receptionist without her permission.	Explain Susan's right to receive her mail unopened and her right to privacy. Ask the facility if this is common practice, reminding them of the regulations and requesting that this practice stop.
While providing care, staff ignore residents and talk to each other about their boyfriends and local parties.	Talk to staff about the importance of recognizing each resident as a person and providing care <i>with</i> the resident not <i>to</i> the resident. Offer to provide training on person-directed care, dignity, and respect.
After talking to a representative, Stan was told by facility staff not to share his concerns with anyone outside of the facility; he should talk to the Social Service Director and not the LTCOP.	Explain Stan's rights to communicate with a representative without interference from facility staff. Offer to provide training on residents' rights and the LTCOP. Ask Stan if he would like you to attend a Resident Council meeting to remind residents of their right to speak with the Ombudsman.

Planning and implementing care

The resident has the right to be informed of, and participate in, their treatment, including the right to:

- Be fully informed of their health status and medical condition in a language they can understand
- Participate in the development and implementation of their person-centered plan of care

This regulation is intended to ensure that residents and resident representatives are included in all areas of person-centered and person-directed care planning and that the planning supports the resident's goals, choices, and preferences related to daily routines, care, and treatment.

Rights Violations	Ombudsman Program Advocacy Examples
The facility has a care plan meeting without allowing Carl to participate.	Explain Carl's right to participate in decisions affecting his care and life in the facility. Encourage Carl to request another meeting where he can be involved.
Anna tells the nurse and several CNAs that she no longer wants to be on dialysis, but her request is not addressed in her care plan.	Explain Anna's right to be informed of the consequences of stopping dialysis and her right to refuse treatment. Empower Anna to talk to her doctor and to request another

	care plan meeting. Let her know she can invite anyone she feels should attend.
Margaret has dementia and is very scared and uncomfortable with male CNAs giving her a shower, but they are often assigned to her. Margaret has begun to express her fear and has hit a CNA. Although her daughter addressed this concern during the care plan meeting, nothing was changed in the care plan.	Encourage Margaret and her daughter to request another care plan meeting to discuss the specific concern. Offer to attend in support of Margaret and explain Margaret's right to feel safe during her shower and the responsibility of the facility to ensure her needs and preferences are met.
Dan repeatedly says he wants to move out of the nursing facility and into the assisted living where his wife resides, but his goal is not included in the care plan.	Talk to the facility about Dan's wishes to move out and encourage Dan to request a care plan meeting to address his goal.

Choice of attending physician

The resident has the right to choose their attending physician.

While the resident has a right to choose a personal physician, this does not mean that a resident is required to do so. It also does not mean the physician chosen by the resident is obligated to provide services to the resident.

Facility staff may not interfere with the resident's choice of a physician(s) (e.g., primary care or specialist). If a resident does not have a physician, or if the resident's physician becomes unable or unwilling to continue providing care to the resident, facility staff must assist the resident or the resident's representative in finding a replacement.

Rights Violations	Ombudsman Program Advocacy Examples
The facility automatically assigned its medical director as Tony's physician when he entered the facility. He was not given the choice to use his own doctor whom he has seen for 20 years.	Explain Tony's right to choose his own physician and encourage him to ask if his doctor is willing to continue to treat him while he stays in the nursing facility.

Respect and dignity

The resident has a right to be treated with dignity and respect, including the right to:

- Be free from physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms
- Retain and use personal possessions

- Receive services in the facility with reasonable accommodation of resident needs and preferences
- Share a room with a spouse or another resident when both individuals live in the facility and both consent to the living arrangement
- Receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed

All residents have a right to be treated with dignity and respect. In addition, all residents' possessions, regardless of their value, must be treated with respect. Providing for resident needs and preferences is essential to creating an individualized home environment. Residents have the right to share a room with whomever they wish if both residents agree. These arrangements could include opposite-sex and same-sex married couples or domestic partners, siblings, or friends.

Rights Violations	Ombudsman Program Advocacy Examples
Dorothy is new to the facility and has some problems with her memory. She was found in the facility kitchen one night so the facility put a chair alarm on her recliner and told her she can't leave her room.	Explain that the facility cannot restrain Dorothy for their own convenience. Determine what the concern is with Dorothy walking around the facility and discuss appropriate means to assure her independence, mobility, and safety.
Charles moved into the nursing facility and his only remaining possession is a quilt that his wife made. He has asked that staff do not touch it, but they don't respect his wishes. One time, he found it in another resident's room.	Explain that the facility staff should be respectful of Charles' personal property. The facility has a responsibility to ensure all staff understand and respect his wishes.
Diane and Denise develop a same-sex relationship while living in the facility and want to share a room. Both have decisional capacity. There is an open room, but the facility will not let them move in together because Diane's son refuses to agree to the arrangement.	Remind the facility of Diane and Denise's right to live together. Encourage all parties to meet and discuss the concern but point out that the decision is ultimately up to the Diane and Denise.

Self-determination

The resident has the right to, and the facility must promote and facilitate, resident self-determination through support of resident choice including, but not limited to, the right to:

- Choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with their interests, assessments, and plan of care

- Make choices about important aspects of their life in the facility
- Interact with members of the community and participate in community activities both inside and outside the facility
- Receive visitors of their choosing at the time of their choosing
- Deny visitors
- Immediate access to the Ombudsman program
- Organize and participate in resident and family groups
- Participate in other activities, including social, religious, and community activities
- Choose to or refuse to perform services for the facility
- Manage their financial affairs

The facility must support and accommodate each resident to exercise their autonomy regarding those things that are important in their life, including interests and preferences. Residents have the right to make choices about their schedules that are consistent with their interests, assessments, and care plans. Facilities must not develop a schedule for care, such as waking or bathing schedules, for staff convenience and without the input of the residents.

Rights Violations	Ombudsman Program Advocacy Examples
<p>Marie says she is bored and wants to feel useful. She asked staff if she can help around the facility, such as folding napkins, or helping the Activity Director with setting up activities, but was told no because they can't allow residents to "work" in the facility.</p>	<p>Encourage Marie to talk with the Activity Director again and offer to go with her. Encourage Marie to request a care plan meeting to address her boredom and desire to help around the facility. Offer to talk to facility staff about Marie's right to choose her activities. Residents can perform duties of their choice within the facility if it does not infringe upon other resident's rights.</p>
<p>Jack is the Resident Council President, and he says the Council does not want staff to be in the meeting the entire time, only when there are specific concerns the Council wants to address with staff. Staff insist on staying throughout the entire meeting.</p>	<p>Explain to Jack and the Council that they have a right to meet independently and others who are not residents must be granted permission from the Council to attend all or part of any Resident Council meeting. Offer to go with Jack to talk to the staff members who are infringing upon the Council's rights.</p>
<p>Staff are waking residents at 4:00 a.m. to get ready for their day. During the Resident Council meeting, residents complain and say they don't want to get up that early.</p>	<p>Explain to the residents they have a right to get up at a time of their choosing. Empower the Council to address their concern with the facility and offer to talk to the DON about residents' right to wake up at the time of their choosing.</p>

Information and communication

The resident has the right to be informed of their rights and of all rules and regulations governing resident conduct and responsibilities during their stay in the facility.

The resident has the right to access their personal and medical records.

- When *accessing* records, the facility is required to provide the information in the form or format requested (if available) within **24 hours**, excluding weekends.
- The resident has a right to *obtain a copy* of their records within **2 working days** of request.

The resident has a right to send and receive mail. The facility must protect and facilitate residents’ right to communicate, including reasonable access to:

- a telephone;
- the internet (where available); and
- stationery, postage, writing implements and the ability to send mail.

The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and internet research.

The facility is required to ensure each resident knows their rights and responsibilities prior to or upon arriving, as appropriate during the resident’s stay, and when the facility’s rules change. Residents may verbally request to see their personal and medical records. The facility may charge a reasonable fee for providing a copy of the requested records, whether in paper or electronic form. Reasonable access means that telephones, computers, and other communication devices are easily accessible to residents and are adapted to accommodate residents’ needs and abilities, such as hearing or vision loss.

Rights Violations	Ombudsman Program Advocacy Examples
Mae asks to see her records but is told that they are all in electronic form and no one has time to sit with her and go through them.	Explain Mae’s right to see her records within 24 hours of her verbal request.
George can only visit his daughter via video calls because she lives in another state. When he asks to use the residents’ computer, he is always told it is not working properly or that someone else is using it. George hasn’t talked to his daughter in months.	Talk to the facility about figuring out a way for George to communicate with his daughter and providing him reasonable access to the computer.
The facility refuses to post the most recent	Talk to the facility administrator about the

survey or make available the survey results.	requirement to post and prominently display survey results in an easily accessible manner and in a common area.
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Privacy and confidentiality

The resident has a right to personal privacy and confidentiality of their personal and medical records.

Personal privacy includes:

- Accommodations
- Medical treatment
- Written, telephone, and electronic communications
- Personal care
- Visits
- Meetings of family council and resident council

This regulation confirms that each resident has the right to privacy and confidentiality for all aspects of care and services. Residents have the right to personal privacy of their body, personal space, and personal care.

During the delivery of personal care and services, staff must remove residents from public view, pull privacy curtains or close doors, and provide clothing or draping to prevent exposure of body parts.

Rights Violations	Ombudsman Program Advocacy Examples
You walk by Sara’s room and notice that she is sleeping and completely exposed from the waist down.	Immediately go to a staff member and ask them to cover up Sara. Investigate if others are also exposed while their door is open.
You are talking to Mike in his room when the CNA comes in to provide personal care to Matt, his roommate. The aide does not pull the curtain and does nothing to seek privacy for Matt.	Ask the aide to pull the curtain and excuse yourself to the hall until the CNA is finished providing care.
You are visiting Velma, a resident whom the facility has described as a “chronic complainer.” During your visit, staff come in and out of her room several times. Velma expresses her annoyance with the interruptions.	Politely ask the staff to either stop interrupting the visit or to provide a space in which there will be no interruptions – whichever makes Velma more comfortable.
Mildred and Sam have begun an intimate relationship and want to spend some alone time in Sam’s room with the door shut, but facility staff keeps opening the door when they are together.	Explain Mildred and Sam’s right to privacy and encourage both residents and the facility to come up with an agreed-upon way to let staff know when the door is to remain closed.

Safe environment

The resident has a right to a safe, clean, comfortable, and homelike environment including, but not limited to, safely receiving treatment and supports for daily living.

The facility is required to be orderly, sanitary, and free from hazards. It also means lighting, temperatures, and sound levels should be comfortable to the residents. The environment refers to all areas where residents are free to go. The term “homelike environment” in the regulations de-emphasizes the institutional settings and allows the resident to use their personal belongings that support the resident’s opinion of a comfortable living environment.

Rights Violations	Ombudsman Program Advocacy Examples
A puddle of liquid is in the middle of the hallway.	Immediately locate a staff member and ask them to clean it up. Residents are at risk to slip and fall. Stand and wait for the staff to clean the floor.
The night shift staff leaves dirty food trays in the hallway for hours after dinner is served to residents in their rooms.	Talk to facility staff about the unsanitary practice and potential risks to residents.

Grievances

The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal.

Residents have a right to complain about treatment, care, management of funds, lost clothing, or violation of rights, etc. This regulation also ensures that the facility has a policy to address all grievances. Facility staff are responsible for making prompt efforts to resolve a grievance and to keep the resident up to date about any progress toward resolution.

Rights Violations	Ombudsman Program Advocacy Examples
During your last visit, Connie asked for your help with a concern. At the next visit, Connie says staff treat her differently now, after talking to you. Connie says staff are rude and ignore her requests for help.	Explain Connie’s right to present complaints without the fear of retaliation. Offer to talk to staff about the recent concern and offer to provide staff training about residents’ rights and retaliation.
Mark states he has complained several times about cold food but feels like he is getting the run-around from staff.	Explain Mark’s right to receive a prompt response and updates towards getting his complaint resolved. Offer to address his concern with staff.

Contact with external entities

A facility must not prohibit or discourage a resident from communicating with federal, state, or local officials.

This includes, but is not limited to:

- federal and state surveyors;
- other federal or state health department employees;
- representatives of the Office;

- any representative of the protection and advocacy systems, as designated by the state; and
- any representative of the agency responsible for the protection and advocacy systems for individuals with a mental illness.

This means that facility staff must ensure that residents are able to communicate freely with the LTCOP and representatives of federal, state, or local officials.

Rights Violations	Ombudsman Program Advocacy Examples
James tells the facility that he wants to talk to the surveyor during the investigation, but the facility does not inform the survey agency of his wishes.	Explain James’s right to talk to the surveyor and give him the number to the state survey agency so he can speak to a surveyor.

Freedom from abuse, neglect, and exploitation

The resident has the right to be free from abuse, neglect, misuse of resident property, and exploitation. This includes, but is not limited, to freedom from physical punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms.

Each resident has the right to be free from abuse, neglect, and physical punishment of any type by anyone. When a nursing facility accepts a resident, the facility assumes the responsibility of ensuring the safety and well-being of the resident. It is the facility’s responsibility to ensure staff know how to support residents and respond appropriately by providing training on how to prevent, identify, and report abuse, neglect, and exploitation.

Rights Violations	Ombudsman Program Advocacy Examples
Joan complains that the aides are rough with her while providing care.	Discuss Joan’s right to have care provided in a manner that does not result in pain and offer to talk to the supervising nurse.

The LTCOP receives a complaint that residents in the dementia unit are locked in their bedrooms at night.	Visit the dementia unit in the evening, make observations and talk with residents and staff. Educate the staff about the residents' right to be free from involuntary seclusion.
Albert has Alzheimer's disease and when he's in pain or confused he begins to wave his arms. He hit an aide and she hit him back.	Explain Albert's right to be free from physical harm. Offer to conduct a staff in-service on residents' rights and abuse and/or suggest the facility seek an expert in dementia to provide training to staff.

Admission, transfer, and discharge

The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless:

- The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility
- 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
- The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident
- The health of individuals in the facility would otherwise be endangered
- 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
- The facility ceases to operate

Residents have the right to receive a 30-day written notice of a facility-initiated transfer or discharge.

Once the resident enters the facility, it becomes the resident's home. Facilities are required to determine their capacity and capability to care for the residents they admit. Therefore, facilities should not admit residents whose needs they cannot meet based on the facility assessment. The regulation also explains the limited conditions under which a nursing facility can discharge or transfer a resident.

Improper transfers and discharges are complicated. There are several advocacy tools that representatives use to prevent facility-initiated transfers and discharges which will be discussed later in the training.

Discharge/Transfer Definitions Pertaining to Nursing Facilities

Discharge – The movement of a resident from a bed in one certified facility to a bed in another certified facility or other location in the community, when return to the original facility is not expected.

Transfer – The movement of a resident from a bed in one certified facility to a bed in another certified facility when the resident expects to return to the original facility.

Facility-initiated transfer or discharge – A transfer or discharge to which the resident objects, did not originate through a resident’s verbal or written request, and/or is not in alignment with the resident’s stated goals for care and preferences.

Resident-initiated transfer or discharge – Means the resident or, if appropriate, the resident representative has provided verbal or written notice of intent to leave the facility. Leaving the facility does not include the general expression of a desire to return home or the elopement of residents with cognitive impairment.

³⁰ State Operations Manual Appendix PP Guidance to Surveyors for Long Term Care Facilities
<https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf>

Section 5:

Regulatory Process for Nursing Facilities

The Centers for Medicare & Medicaid Services

The Centers for Medicare & Medicaid Services ([CMS](#))³¹ is an agency within the U.S. Department of Health and Human Services (HHS). CMS is responsible for the administration of Medicare and Medicaid services. Certified nursing facilities are “certified” to be able to accept payments from Medicare and/or Medicaid for providing certain services to residents. Certified nursing facilities must comply with certain federal regulations. The specific federal regulation discussed in this Section is the Requirements for Long Term Care Facilities, also known as federal nursing facilities regulations.³²

Enforcement of Residents’ Rights

Among other federal and state laws, nursing facility residents’ rights are defined and clarified in the federal nursing facilities regulations. Rights for individuals living in homes or facilities only regulated by the state are defined and clarified in state rule. Facilities are required to ensure those residents’ rights are upheld.



Learn more about nursing facility enforcement [here](#).³³

State Survey Agency

CMS has an agreement with the state survey agency to conduct surveys (inspections) to determine whether facilities are in compliance with federal regulations. CMS also provides direction to the state survey agency nursing facility inspectors, who are called “surveyors” about how to respond to and investigate complaints and how to conduct annual surveys. There are two types of surveys: the standard survey and the abbreviated standard survey.

The Standard Survey

The standard survey, also called the annual survey, is conducted between 9 and 15 months from the date of the previous year’s survey by a designated team of surveyors. Federal regulations do not allow states to conduct surveys less frequently when facilities have a history of low or no deficiencies from annual inspections. The state survey

³¹ Centers for Medicare & Medicaid Services *Nursing Homes* <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/NHs>

³² CFR 42 Chapter IV Subchapter G Part 483 Requirements for States and Long Term Care Facilities Subpart B - Requirements for Long Term Care Facilities <https://www.ecfr.gov/cgi-bin/text-idx?SID=f64b6edcc2b2ee52bf5de8e19a340569&mc=true&node=sp42.5.483.b&rgn=div6>

³³ Centers for Medicare & Medicaid Services Nursing Home Enforcement – *Frequently Asked Questions* <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationEnforcement/Downloads/NH-Enforcement-FAQ.pdf>

agency is responsible for assuring federal and state regulations regarding quality of care and quality of life are met.

According to the [Long-Term Care Survey Process \(LTCSP\) Procedure Guide](#), surveyors are required to “*Contact the Ombudsman in accordance with State policy. Notify the ombudsman of the proposed day of entrance into the facility and if applicable, obtain any information/concerns. Ascertain whether the ombudsman will be available if residents wish her/him to be present during the Resident Council Interview. Enter the Ombudsman’s name, number, contact date, and areas of concern.*”³⁴



Learn more about how and when the state surveyors are to contact the Ombudsman program [here](#).³⁵

The Survey Team

The survey team consists of:

- Registered nurses
- Nutritionists
- Sanitarians
- Environmental specialists
- Other professionals

The Survey Process

The survey team begins the survey process before entering the building. Offsite preparation for a standard survey includes, but is not limited to:

- Reviewing the facility’s Minimum Data Set (MDS) data (resident assessment data)
- Ensuring enough residents are in the sample pool for interview and/or record review
- Reviewing discharged residents’ records
- Reviewing past or repeat deficiencies
- Reviewing complaints investigated since the last survey
- Reviewing any facility-reported incidents since the last survey
- Determining if complaints will also need to be investigated during the survey
- Assigning surveyors particular tasks and areas to observe

The survey team enters the facility **unannounced** at any time or day of the week, but usually during normal working hours.

³⁴ Centers for Medicare & Medicaid Services *Long Term Care Survey Process (LTCSP) Procedure Guide Effective February 6, 2021* <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/LTCSP-Procedure-Guide.pdf>

³⁵ The National Long-Term Care Ombudsman Resource Center *Ombudsman References in Federal Nursing Home Requirements Page 4* <https://ltcombudsman.org/uploads/files/support/omb-ref-in-nh-regs-april-17-final.pdf>

Upon Entering the Facility

- The survey team coordinator holds a brief entrance conference with the facility administrator to discuss the survey and to ask for items specific for the survey.
- The survey team members begin the survey by going to their assigned area.
- The surveyor assigned to the kitchen conducts a brief initial visit to the kitchen.
- The team coordinator is required to call the LTCOP.

During the Survey

- Surveyors are required to observe and screen **all** residents in their assigned area and observe, interview, and complete a limited record review to determine an initial pool of residents.

It is a good idea to go to the facility prior to the resident meeting to speak with residents who may be interested in talking to a surveyor either during the resident meeting or in private. Arriving early will give you a chance to communicate with residents and empower them to share their concerns with a surveyor.

- Surveyors conduct resident representative interviews (RRI)/ family interviews for residents who are unable to be interviewed. The goal is at least three RRIs the first day.
- Records and MDS indicators are reviewed.
- All resident observations and interviews from the initial pool are completed.
- The first scheduled full meal is observed.
- The surveyors select a sample of residents based on concerns that were observed or disclosed on day one and conduct an in-depth investigation for any area of concern.
- All concerns identified during the survey are investigated.
- Surveyors check for breakdowns in infection control throughout the survey.
- Medication passes and storage are observed.
- Sufficient and competent nursing staffing is considered.



Learn more about Quality Indicator and Resident Reports [here](#).³⁶

Resident Meeting

The surveyor works with the Resident Council President or an active member of the Council to arrange the resident meeting. Surveyors can invite any resident to the meeting. With permission of the Resident Council President, the surveyor reviews three months of Council minutes prior to the meeting to identify any unresolved concerns. If there is no Resident Council, surveyors do not conduct a group resident meeting.

³⁶ MDS 2.0 Public Quality Indicator and Resident Reports <https://www.cms.gov/research-statistics-data-and-systems/computer-data-and-systems/mdspubqiandresrep>

If the representative of the Office has indicated to a surveyor that they want to attend the resident meeting and if the Resident Council President is agreeable, a surveyor informs the LTCOP of the date and time of the resident meeting. Representatives attend the resident meeting to primarily observe the meeting and to support residents. The goal of the meeting is for residents to express concerns and give the surveyor some insight into the care residents receive.

Exit Conference

The exit conference is conducted with the facility administrator to inform the facility of the survey team's observations and preliminary findings. The representative of the Office, the Resident Council President, and one or two other residents are invited to attend. The facility can supply additional information they believe is pertinent to the findings.

Life Safety Code

In addition to the standard survey, an annual Life Safety Code Survey is conducted to determine that the physical environment is safe and meets the standards of the Life Safety Code. This survey may be conducted independently or in conjunction with the standard survey. The Life Safety team will check items such as structural integrity, electrical systems, and compliance with fire codes.



Learn more about Life Safety Code and Health Care Facilities Code Requirements [here](#).³⁷

Abbreviated Standard Survey

An abbreviated standard survey is also known as a complaint investigation. The timing, scope, duration, and conduct of a complaint investigation are at the discretion of the state survey agency.

The complaint investigation is unannounced and is supposed to occur on the specific day or shift of the complaint, when applicable. For instance, if the complaint is about resident neglect that occurs on the weekends, the investigation should take place on the weekends.

When the state survey agency investigates a nursing facility complaint, the surveyor(s) observations, record reviews, and interviews all pertain to the complaint.

The surveyor will determine whether:

- The allegations are substantiated or unsubstantiated
- The facility failed to meet any of the regulatory requirements
- The facility practice or procedure that contributed to the complaint has been changed to achieve and/or maintain compliance

³⁷ Centers for Medicare & Medicaid Services *Life Safety Code & Health Care Facilities Code Requirements*
<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/LSC>

Keep in mind that the purpose of a complaint investigation is to determine if the facility is in compliance with federal and state regulations. An investigation may not always achieve the desired result of the resident or complainant. In most situations, the LTCOP works with the resident and facility staff to try to resolve the complaint before contacting the state survey agency.

Section 6:

Residents' Rights in Residential Care Communities and the Regulatory Process

The role of the Ombudsman program and core advocacy approaches are the same regardless of the setting (e.g., all work is resident-centered; the investigation techniques and resolution process is the same). However, when working with residents in residential care communities there may need to be changes made in advocacy strategies to resolve issues to the satisfaction of the residents. Key similarities and differences between nursing facilities (NFs) and residential care communities (RCCs) are below.

Similarities include:

- Most residents in both environments are older adults.³⁸
- Many of the same services are provided in both settings (e.g., administering medications and providing assistance with activities of daily living).
- Characteristics of residential care community residents are becoming increasingly like those of nursing facility residents (e.g., similar acuity levels, many of the residents have some form of dementia).³⁹
- Residents in residential care communities often experience a sense of loss and grief similar to individuals living in nursing facilities.

Differences include:

- Unlike nursing facilities, there are no federal regulations specifically for residential care communities, and state regulations and enforcement vary. However, there is a federal regulation regarding how states use federal Medicaid funds to pay for home and community-based services (Home and Community Based Services [HCBS] final rule).⁴⁰ Despite federal regulations related to Medicaid-funded HCBS services there is no Medicaid entitlement to HCBS services. Therefore, in some states there may be wait lists or no services available for people who rely on Medicaid to pay for their long-term services and supports.
- Residential care community operators and staff frequently have less training than nursing facility administrators and staff.
- Operators in some residential care communities are providing care in their own personal home.
- States may or may not have a “Bill of Rights” for residential care communities.
- Some residential care communities serve individuals with mental or behavioral health needs.

³⁸ *Long-Term Care Providers and Service Users in the United States: Data from the National Study of Long-Term Care Providers*. U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. February 2016. Page 105. https://www.cdc.gov/nchs/data/series/sr_03/sr03_038.pdf; “Who Lives in Assisted Living?” AssistedLivingFacilities.org. CDC data cited. <https://www.assistedlivingfacilities.org/resources/who-lives-in-assisted-living/>.

³⁹ *Long-Term Care Providers and Service Users in the United States: Data from the National Study of Long-Term Care Providers*. U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. February 2016. Page 40. https://www.cdc.gov/nchs/data/series/sr_03/sr03_038.pdf.

⁴⁰ NORC Home and Community Based Services (HCBS) page includes information regarding the final rule. <http://itombudsman.org/home-and-community-based-services/hcbs-reports-resources#regulations>

The unique features of residential care communities, such as the lack of federal regulations, variation in state regulatory oversight, and small size of some homes, require adapting some advocacy and/or communication strategies or developing new strategies. Ombudsman program representatives must utilize approaches that are based more on resident agreement or contract provisions, their ability to develop a connection with the provider, and their skills in convincing the provider to take certain actions. These strategies are also used in advocacy for residents living in nursing facilities but become much more important in residential care communities due to the differences in regulations.

Residential care communities (RCCs) vary from state to state. RCCs are required to follow state regulations pertaining to each license or certification type.

If Medicaid is paying for a non-nursing facility setting, such as an assisted living or a personal care home, then the federal government has some basic standards and requirements for states to meet. States are required to develop plans that align with the Home and Community-Based Services federal regulations. These regulations can also be an extra advocacy tool for LTCOPs.

The HCBS Settings Rule requires that all home and community-based settings meet certain qualifications. These include:

- the setting is integrated in and supports full access to the greater community;
- the setting is selected by the individual from among setting options;
- individual rights of privacy, dignity and respect, and freedom from coercion and restraint are ensured;
- autonomy and independence in making life choices are optimized; and
- choice regarding services and who provides them are facilitated.

The HCBS Settings Rule includes additional requirements for provider-owned or controlled home and community-based residential settings.

These requirements include:

- the individual has a lease or other legally enforceable agreement providing similar protections;
- the individual has privacy in their unit including lockable doors, choice of roommates, and freedom to furnish or decorate the unit;
- the individual controls his/her own schedule including access to food at any time;
- the individual can have visitors at any time; and
- the setting is physically accessible.

The experiences and concerns expressed by residents in RCCs could be similar or different than those living in nursing facilities. The concepts such as person-

directedness, self-determination, empowerment, and proper assessments and care or service planning discussed in this training apply to residents in all settings. Despite differences in laws and regulations, most of the advocacy examples discussed in the previous section apply to residents living in residential care communities. Regardless of the facility type, the role of the Ombudsman program does not change.



The following video: [The Thin Edge of Dignity](#),⁴¹ is about Dick Weinman, retired professor of broadcast communications at Oregon State University, author, and former radio personality. Dick delivers a moving presentation about his experience in an assisted living facility.

When viewing this video, think about what types of person-centered practices might be put into place to better accommodate older adults and people with disabilities.

Discussion questions:

1. What is your biggest take-away from the video?
2. When admitted, Dick became #108, which is his room number - this is how staff refer to him. Further, staff call him Richard as opposed to his preference to be called Dick. How do you think it feels not being called by your preferred name, and instead to be referred to by your room number?
3. Dick talked about showering and how it makes one feel vulnerable and uncomfortable. He also talked about going to the bathroom and how it can be a degrading experience when you cannot do it yourself. How would you begin to talk with facility caregivers about this?
4. Dick mentioned that he had an active social life prior to his accident but activities in the assisted living are minimal. What are some of the activities he mentioned available to him at the assisted living? Do these activities sound like things you would want to do?
5. What do you think about Dick's idea that when a new resident moves in there should be a "welcome wagon" group to help mentor and get the new person oriented to their new home?

Regulatory Process for Residential Care Communities

⁴¹Oregon Department of Human Services, Silverman Studios Video Production, *The Thin Edge of Dignity Dick Weinman | Assisted Living Documentary* <https://www.youtube.com/watch?v=UciTFCPCivl>

Section 7:

Conclusion

Module 4 Questions

1. The LTCOP advocates for quality of _____ and quality of _____ for people who live in nursing facilities and _____.
2. Name three rights all residents have and explain how you might advocate when they are violated.
3. A nursing facility changed breakfast time from 8:00 a.m. to 7:00 a.m., but a group of residents don't want to get up that early. Do residents have a say in the time change?
4. A resident tells you they want to watch television in the living room of the assisted living in the late hours of the evening. The manager said no because the TV must be off at 8:00 p.m. as it keeps other residents awake. Who does the LTCOP represent, the complainant or those who go to bed at 8:00 p.m.?
5. Name one thing a state surveyor looks at when they enter the facility for a standard survey.
6. True or False? Surveyors are required to notify the LTCOP after entering an RCC.