

OMBUDSMAN ADVOCACY CHALLENGES IN ASSISTED LIVING:

Outreach and Discharge

Prepared by National Association of State Units on Aging

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OMBUDSMAN ADVOCACY CHALLENGES IN ASSISTED LIVING: OUTREACH AND DISCHARGE

Introduction

Ombudsman responsibilities as specified in the Older Americans Act apply to all *long term care facilities*. However, until recently, State Long Term Care Ombudsmen (SLTCOs) have concentrated most of their efforts in nursing homes. They have been advocates for residents and for industry-wide change. They have handled and resolved myriad complaints with limited resources, staff and volunteers. They have educated consumers and providers, have worked with partners in the community and are widely known and respected in the nursing home world. But their responsibilities do not end there and the long term care industry is rapidly changing.

The charge to State Long Term Care Ombudsmen under the Older Americans Act includes advocating for residents in all board and care, assisted living or "other adult care homes."¹ Ombudsmen have identified three major challenges in providing advocacy services to assisted living residents.

1. **The advocacy role of the Long Term Care Ombudsman Program in assisted living is complicated by regulations and settings that often differ markedly from nursing homes.** Furthermore, the volunteer model that has worked in nursing homes may not always work in assisted living, especially when the physical structure consists of private resident apartments. In addition, Ombudsman Programs may not have developed educational materials specific to assisted living or be prepared to train staff and volunteers to respond to the many advocacy challenges presented in these settings.
2. **Residents of assisted living facilities, their families, assisted living providers, and licensing agencies often do not know that the Ombudsman Program has responsibility for providing advocacy in this arena,** and so, are less likely than nursing home residents, operators, or licensing agencies to call the Ombudsman for assistance and information on assisted living.
3. **The Ombudsman Program's resources, in terms of funding, staff, and volunteers, are limited** and the program struggles to keep up with new and increasingly complex problems that have an impact on nursing home residents. With its traditional focus on nursing home advocacy, the Ombudsman Program in many states has been able to focus only limited resources on assisted living advocacy.

¹ Terms used by states include assisted living, board and care, residential care, adult foster care, adult homes, homes for the aged, and housing with services. For the purposes of this paper, the term assisted living facility (ALF) will be used for any and all of these terms.

While recognizing that many consumers view assisted living as a more appealing long term care option than nursing home placement, Ombudsmen nevertheless have numerous concerns about consumers' ability to get the services they need in this setting. Many of these concerns arise from the fact that Ombudsman involvement in assisted living advocacy often revolves around discharge or the threat of discharge. A synopsis of these concerns is provided below.

- **Consumers and their families are often confused about what assisted living offers.** The number of assisted living facilities and consumers who choose assisted living has steadily increased during the past decade. Assisted living holds out great promise to consumers who want to “age in place” and who do not want to spend their final years in an institution without the privacy and choices they could have in their own homes. However, assisted living has not always lived up to its promise. Consumers who thought the move to assisted living would enable them to avoid having to go to a nursing home are often surprised to be faced with a discharge notice.

Ombudsmen have identified concerns with providers whose promotional materials seem to promise “aging in place” without limits, when in reality, the capacity of the assisted living provider to provide care, in terms of staff knowledge, qualifications and skills, is limited. Facilities that promote themselves as specialists in dementia care may not be meeting the resident’s needs for supervision, or a facility may seek to discharge a resident with Alzheimer's Disease when the resident’s needs for supervision and assistance increase to the point where additional staff are needed to provide care. The contract residents sign when they enter a facility may not clearly specify what services are available and what happens when/if care needs increase.

Sometimes assisted living providers find that the service needs of new residents exceed their expectations. This may be due to being given misleading information from relatives eager to get their loved ones settled in assisted living. According to Ombudsmen, inadequate assessments of prospective residents by assisted living providers are also a problem. Even if the state’s assisted living regulations permit additional services, such as home health or therapies, to be brought into assisted living, Ombudsmen find that providers are sometimes reluctant to encourage such arrangements and are more likely to discharge the resident instead. Furthermore, assisted living facilities may choose not to provide as high a level of care as permitted by the state’s regulations.

- **Assisted living regulations may not address clearly the issues that concern many consumers and the Ombudsman Program.** For example, the regulations may set minimal or no specific staffing requirements (e.g., qualifications, numbers and training), or may limit who can receive services in this setting (e.g., some state regulations will not permit assisted living providers to serve residents who need a nursing home level of care). Where the regulations are more flexible in defining who can be served in assisted living, the facility still may not be the appropriate setting for some residents if staff are not properly trained.

- **Assisted living may not be available to persons who cannot pay privately and specific information on what the fees cover and how they might increase is often not spelled out.** As assisted living residents' care needs increase, the agreed upon monthly fees also are likely to increase. Thus, residents may use up their savings and need public assistance to help pay for their care. All too often, residents find that when they can no longer pay privately for assisted living, funding to help pay for this service is not available or the facility where they live does not accept Medicaid or other public payment.
- **Residents' rights protections in assisted living are likely to be less specific than the rights protections provided to nursing home residents.** Residents may not have the right to appeal an involuntary discharge from an assisted living facility. Indeed, the specific circumstances under which discharge is permitted may be vague and residents may not have the right to receive written information specifying the reason for discharge, adequate notice of the planned discharge or the right to obtain assistance from the facility in developing a post-discharge plan of care.

Approach Used in Developing this Paper

The National Association of State Units on Aging (NASUA), as part of its work plan under the National Long Term Care Ombudsman Resource Center (NORC), initiated information collection on Ombudsman involvement in assisted living discharges through a brief written survey sent via email to 20 State Long Term Care Ombudsman Programs identified as having experience working in the assisted living arena.² Ombudsmen were asked about: the kinds of information on assisted living discharges that would be most useful in their daily work; how their state's assisted living regulations address discharges and appeals; whether the program has developed consumer materials on assisted living; and the kinds of assisted living cases the programs have handled. (The survey form is attached in Appendix A.) The survey was sent out in February 2000. We received 17 responses.

From the information gathered via the written survey, we selected six State Ombudsman Programs for in-depth interviews. Telephone interviews were conducted with:

- Virginia Fraser, Colorado State Ombudsman
- Becky Kurtz, Georgia State Ombudsman
- Marguerite Schervish, Andy Farmer and Chris Tandlund, Michigan State Ombudsman Program
- Sharon Zoesch, Minnesota State Ombudsman
- Meredith Cote, Oregon State Ombudsman
- Kary Hyre and Louise Ryan, Washington State Ombudsman Program

² Alabama, Colorado, Connecticut, Georgia, Hawaii, Illinois, Maine, Maryland, Michigan, Minnesota, Missouri, New Mexico, Ohio, Oklahoma, Oregon, South Dakota, Washington, Wisconsin, Wyoming, and the District of Columbia.

The interviews included discussion of specific cases the programs have handled; discharge and appeal rights provided assisted living residents under their state's regulations; and policies, practices and/or training specific to assisted living these Ombudsman Programs have developed. (The interview questions can be found in Appendix B.)

As we gathered information on these Ombudsman Programs' experiences with assisted living discharges, it became clear that *the degree to which the program gets involved in such cases depends on its success in reaching assisted living consumers and providers in the first place*. According to the Ombudsmen we interviewed, assisted living consumers and providers are generally far less knowledgeable about the Ombudsman Program's advocacy role than the typical nursing home resident or provider. The relatively low number of assisted living complaints handled nationally by the program may reflect this situation. (In 1998, the total number of complaints for board and care and similar facilities was 34,696 compared to 163,540 for nursing facilities.)³

To ensure the usefulness of this paper on assisted living discharges to all Ombudsman Programs – including those who have had very little experience in this arena and who want to be more proactive in assisted living advocacy – we decided to broaden our information collection to include questioning the Ombudsman Programs we interviewed about their outreach efforts targeted to assisted living consumers and providers. The paper begins with a section on “Ombudsman Outreach in Assisted Living,” describing some of the challenges Ombudsman Programs face in doing assisted living outreach and practical steps Ombudsmen themselves have identified for more effectively reaching assisted living consumers and providers. The second section of the paper focuses on “Ombudsman Intervention in Assisted Living Discharges.”

SECTION 1: OMBUDSMAN OUTREACH IN ASSISTED LIVING

Outreach to Consumers

The Ombudsmen we interviewed agreed that assisted living residents, prospective residents, and their families often do not know the Ombudsman Program provides advocacy in this arena. They described a number of situations that underscore the need for more outreach by the program to assisted living consumers:

- Residents and families often are unaware of consumers' rights in assisted living;
- Families and residents sometimes think they cannot challenge the assisted living facility's decisions about admissions and discharge;
- Consumers are reluctant to complain, especially in smaller facilities where they sometimes lack the opportunity to report complaints anonymously;
- Some residents and their families fear provider retaliation if they complain to an Ombudsman.

³ Administration on Aging, FY 1998 Long Term Care Ombudsman Report, Appendix A, tables A-3, A-4.

Adding to the complexity of assisted living outreach is the fact that some older consumers make the decision to go into assisted living themselves, whereas others are placed in assisted living by family members. Consumers who choose assisted living for themselves and families who place loved ones in this setting share the view that a move to a nursing home in the future will not be necessary and that residents of assisted living may “age in place.” However, Ombudsmen report some differences in expectations between the two types of decision-makers. For instance, families are more likely to expect services to be provided as they would be in a nursing home, with nurses available to supervise and provide care. Families also may be defensive about their choice of assisted living over nursing home care, since assisted living usually is less costly.

Educating Consumers About The Ombudsman Program’s Role in Assisted Living

The Nursing Home Reform Act of 1987 outlines basic rights for nursing home residents and lays the groundwork for educating consumers and providers about the Ombudsman Program. By law, nursing homes are required to provide information on the program to all new residents and post the name and phone number of the local Ombudsman in a prominent place. This requirement provides an automatic vehicle for consumer education. States’ assisted living regulations may not specify a role for the Ombudsman Program in this setting. Thus the Ombudsman Program in each state is challenged to identify the best way to reach assisted living consumers.

Two of the Ombudsman Programs we interviewed – in Georgia and Minnesota – report that their states require new assisted living residents to be given information about the State Long Term Care Ombudsman Program.

- Minnesota regulates assisted living under its home care licensure statute. The “Home Care Bill of Rights” requires information on the Ombudsman Program to be given to all home care recipients, including those receiving assisted living services. This information must be provided when a consumer begins receiving assisted living or home care services, when there is a change in the service plan or services costs, and when the consumer receives a notice of service termination.
- Georgia’s personal care home regulations state that every resident has the right to information on the Long Term Care Ombudsman Program and the name, address, and telephone number of the State Ombudsman must be posted in a common area in the facility. In response, the Georgia Ombudsman Program has developed and disseminated posters to personal care providers that include contact information for the Ombudsman Program.

In states where such requirements do not exist, Ombudsmen can use a variety of approaches to ensure that consumers know about the program’s role as an advocate for assisted living residents.

Practical Steps:⁴

- Develop brochures, fact sheets and other materials specific to assisted living.
- Disseminate to consumers and providers assisted living-specific materials that either the Ombudsman Program or a partner program (e.g., APS, Legal Services, etc.) has developed.
- Provide materials that describe the Ombudsman Program and its role in assisted living to assisted living providers. Provide similar information to other organizations likely to come in contact with assisted living consumers and families.
- Develop and conduct community presentations on assisted living and the Ombudsman's role in this setting.
- Address the special challenges in assisted living settings where residents live in private apartments. Ombudsmen may be able to reach such residents by making use of bulletin boards or other centralized communication systems and by distributing flyers to individual apartments. If a community room exists in the facility, Ombudsmen might get the provider's permission to place its program brochures and posters there.

Adapting the Ombudsman Volunteer Model to Assisted Living

When volunteers make regular visits to nursing homes, they become recognized by the residents, residents' families and providers who gain knowledge about and confidence in the program. The physical environment of some assisted living facilities, e.g., large apartment-style facilities, may not be conducive to getting to know the residents through casual meetings like those that may occur when a volunteer walks up and down the halls of a nursing home.

In Oregon and Michigan, the Ombudsman Program finds it challenging to recruit volunteers for assisted living facilities. Ombudsman programs may need to create new approaches for using volunteers in assisted living that take into consideration the following issues:

- Volunteers may not be as familiar with assisted living regulations and/or they may feel uncomfortable in a setting that generally has less specific regulations than nursing homes;
- Volunteers in assisted living may encounter providers who don't know about the Ombudsman Program and therefore are not receptive to volunteer visits;
- Volunteers require specific training to prepare them to work in assisted living, including pointers for getting access to residents who live in apartment-like settings and making visits to residents in smaller homes where privacy may be limited.

⁴ Advocacy Practices in Assisted Living: A Manual for Ombudsman Programs. Section 3 provides examples of consumer educational materials and educational initiatives in assisted living developed by Ombudsman Programs. See: Minnesota, p 3.8; Montana, p 3.9.

Practical Steps:

- Train staff and volunteers regarding assisted living regulations and the challenges of providing advocacy in this setting.⁵
- If the program has had difficulty recruiting volunteers for assisted living, consider the following:
 - Establish a more flexible schedule for visiting assisted living facilities, e.g., permitting less frequent visits to small or rural facilities might make this setting more appealing to some volunteers.
 - Encourage new volunteers to go to assisted living, as the Washington State Ombudsman does. The Washington Ombudsman Program provides a 40 hour orientation and training for new volunteers. The volunteers visit all three facility types as part of their initial training – adult foster homes with 3 – 6 residents, boarding homes with 7 + residents (typically 60 – 80 beds; ALFs are licensed in this category), and nursing homes. The program assigns volunteers near where they live and encourages Ombudsman assignment to assisted living because of the growth of this industry. The Washington State Ombudsman finds that the assisted living facilities appeal to the volunteers because many of the facilities are newer, the atmosphere is more upbeat, and the residents are usually more independent and healthier than in nursing homes.
 - Recruit seasoned Ombudsman volunteers for assisted living as Oregon does. Oregon has developed a volunteer role known as “Adult Foster Care Home Specialist.” These volunteers come from the ranks of Oregon’s Certified Ombudsman Investigators who complete a three-day advanced training in visitation, reporting and handling complaints. Candidates identified for the foster care ombudsman role go through an additional one day training. Experienced Ombudsmen who serve in this setting dialog with the trainees and answer questions regarding the unique nature of foster care homes and the challenges they present to Ombudsmen. The “graduates” of this additional training receive badges that identify them as “Adult Foster Care Specialists.”

Ensuring Privacy and Confidentiality

Residents in assisted living facilities may be intimidated by the provider and reluctant to speak with an Ombudsman or to voice complaints. A potential fear of residents identified by the Ombudsmen with whom we spoke is being asked to leave the assisted living facility if they voice complaints.

⁵ Advocacy Practices in Assisted Living: A Manual for Ombudsman Programs. Section 3 briefly describes Ombudsman training programs focused on assisted living facilities in several states: Maryland, North Carolina, Oklahoma and Wisconsin, p 3.6.

Case example: Ombudsman intervention to prevent retaliation after residents voice complaints *A group of paralyzed, ventilator-dependent, male residents all of whom lived in the same home, met with the Ombudsman to voice their complaints about inadequate staffing. Under Minnesota regulations, a provider is responsible for arranging assisted living services and the fee paid to the operator is expected to cover the cost. When the provider/owner learned of the resident's request for more staff, he threatened to close the facility, which would have meant the residents might end up in a hospital until nursing home beds could be found. The Ombudsman assisted the residents to contact other home care service providers, and explore options for meeting their respiratory therapy and other care needs. Ombudsman intervention in this case allowed the residents to choose the home care agency they wanted, continue to receive respiratory therapy from the original service provider who had threatened withdrawal of this service, and the home stayed open.*

Washington's boarding home licensing regulations and the state's Ombudsman statute specify that facilities can be fined if they "interfere with the work of the Ombudsman." This law is well enforced and facilities are fined if the Ombudsman is denied access. The state also has a "whistle blower" law that protects employees, residents or Ombudsmen against retaliation and imposes fines for misconduct; however, this law is less well enforced and Ombudsmen are concerned about how to protect residents against retaliation if they voice complaints. To address this concern and ensure resident confidentiality, Washington Ombudsmen sometimes meet with residents outside the facility.

The Ombudsmen we interviewed identified a new trend: some assisted living providers are installing audio/video monitors in residents' rooms. Monitors may be left on all the time and residents may not always be aware that the monitors are turned on. While these devices may facilitate staff checking on residents more frequently to ensure their safety, they present new challenges for ensuring residents' privacy. It is essential for Ombudsmen to be alert to the presence of video or audio monitors and take appropriate steps to ensure residents' privacy and confidentiality (see Practical Steps below for some ideas).

In small adult foster care homes with five or fewer residents, residents may not be comfortable receiving visits from an Ombudsman, and it may be difficult to find private space for a conversation. Both Oregon and Georgia have found it helpful to use a "buddy system" when an Ombudsman visits smaller facilities or facilities where the Ombudsman has encountered problems in the past (described below under Practical Steps).

Practical Steps:

- Train volunteers and staff to be alert to the presence of audio and/or video monitors. When such devices are present, Ombudsmen should, with the resident's permission, ask to have them turned off during their visit.
- If there is no place in the facility where ombudsmen and the resident can meet privately or the resident is concerned about being seen with an Ombudsman, arrange for an off-site visit with residents.
- Develop a "buddy system" for Ombudsman visits, following the Oregon or Georgia models.
 - In Georgia, when the Ombudsman encounters a facility where it is difficult to talk privately with residents due to an ever-present provider, Ombudsmen visit the facility in pairs. While one Ombudsman talks with the provider, using the opportunity to provide education on residents' rights and the Ombudsman's role in assisted living, the second Ombudsman visits with the resident(s). Thus, privacy and confidentiality are assured during the interview.
 - In Oregon, certified volunteers must initiate the "buddy system" in all types of long-term care facilities when certain risks are identified: encountering a hostile, argumentative or highly defensive caregiver; or visiting a facility with a history of serious problems. In situations where a "buddy" is required, two volunteers must stay together at all times when visiting the facility. This arrangement provides a witness to the conduct of the Ombudsman volunteer, a second witness to the behavior of the caregiver, and a second investigator on the complaint. (See Oregon's Policy/Procedure 201 "Implementing the Buddy System" in Appendix C.)

Outreach to Providers

The Ombudsmen we interviewed agreed that assisted living providers are often not familiar with the Ombudsman Program's role in assisted living. Ombudsmen may need to provide basic information to assisted living providers about the program, as well as educate them on residents' rights. Providers – especially in smaller homes – are sometimes not familiar with assisted living regulations and may have little understanding of residents' rights. In many small facilities, there is often no place for Ombudsmen and residents to have a private conversation. The provider may have set a limit on the hours that residents can have visitors and may even try to restrict certain visitors (e.g., family members who have previously made a scene or disturbed other residents). Ombudsmen also are less likely to receive a request for information/consultation from an assisted living provider than from a nursing home administrator.

Educating Assisted Living Providers

Georgia has found that the Ombudsman Program must first educate personal care providers in order to “get in the door.” To accomplish that, the program requires each regional Ombudsman Program to present at least one training event per year for personal care home providers. Some local Ombudsman Programs fulfill this requirement by having joint training events with county Cooperative Extension Programs. Cooperative Extension staff have expertise in nutrition and home safety and are often willing to take care of the logistics, such as finding a location to hold the training. The regulatory agency supports the Ombudsman Program’s efforts through approval of these events for continuing education hours for personal care home staff.

Practical Steps:

- Develop and/or disseminate brochures, fact sheets, and other materials to assisted living facilities about the Ombudsman Program and its role in assisted living.
- Distribute materials to providers through personal contacts, partnering with regulatory and licensing agencies or cooperative efforts with other community agencies.
- Conduct training sessions for assisted living providers on the Ombudsman Program’s advocacy role and residents’ rights.⁶ Focus on problem areas, which may include residents’ right to have private visits with persons of their choice and to make complaints.

⁶ Refer to Advocacy Practices in Assisted Living: A Manual for Ombudsman Programs. Section 3 identifies states where Ombudsman training programs and materials have been developed for assisted living administrators and staff. See: Alaska, Florida, New Hampshire and Washington, p. 3.7; Colorado, p 3.8.

SECTION 2: OMBUDSMAN INTERVENTION IN ASSISTED LIVING DISCHARGES

Assisted living regulations either may not clearly define admission criteria, creating confusion for consumers and providers alike, or identify specific resident conditions as inappropriate for assisted living, thus restricting who can be cared for in this setting. For instance, Washington's regulations require that a resident who is bedbound for fourteen days or longer must be discharged (this rule is currently being reviewed), and the Fire Marshall may precipitate a discharge if a resident is unable to exit the facility independently. In Georgia, the regulatory agency may require discharge if it determines that the care needs of the resident are too heavy for the facility. The Georgia Ombudsman reports that this is a recurring issue, particularly with Medicaid waiver residents.

There is variation in states' assisted living regulations with regard to discharge. Consumer protections, including requirements for a written notice, the amount of notice which must be given and appeal rights, may or may not be addressed. Furthermore, allowable reasons for discharge may be so specific that there is little room for negotiation on behalf of a resident who wants to stay in the facility (e.g., resident has a catheter, resident is unable to get out of bed without assistance), or broadly stated and open to interpretation (e.g., the facility is unable to meet resident's needs, resident is a danger to self or others).

Though regulations regarding who may be cared for in assisted living may vary from state to state, the six (6) State Ombudsmen we interviewed agreed that the reasons most often cited for discharge include:

- The resident needs more care than the facility can provide;
- The resident is a danger to self or others;
- Medication administration issues; and
- Non-payment

Ombudsmen who have been successful in educating assisted living consumers and providers and developing relationships with providers and regulatory agencies are more likely to be successful in averting an involuntary discharge, even when the regulations do not specify consumer protections. The Ombudsmen we talked to report some success in bringing together the resident and the provider to negotiate a solution to a threatened discharge that is mutually agreeable.

The Resident Needs More Care Than The Facility Can Provide

Specific concerns that Ombudsman have identified include:

- After entering the facility, the resident may learn that the provider is unable to provide needed services. Ombudsmen report that providers often are not sufficiently trained to do accurate assessments of residents' service needs, and

sometimes families inadvertently withhold or deliberately hide relevant information about the resident in order to expedite an admission to assisted living.

- The facility may not keep the promises it made before the resident entered the facility. The facility's brochures or other marketing materials may offer services such as medication administration, supervision for disoriented residents, and other individual care services that the facility cannot provide due to insufficient or inadequately trained staff, or licensing rules that restrict the kinds of services that may be provided.
- The resident may have signed a contract with the facility without fully understanding the limits on the services, which may be provided. When the resident later requires services not in the contract, s/he may not be able to afford the cost of more hours of service or more complex care, or the facility may not be willing or able to provide more services even if the resident is able to assume the cost.
- The resident's condition may deteriorate to the point where s/he has care needs beyond what the facility is able to handle. The facility may be insufficiently staffed or not have appropriately trained staff to meet the needs of residents who require constant care or supervision, or the regulations may require discharge.

The Resident is a Danger to Self or Others

"Disruptive behavior" often is the reason given for discharge from assisted living. In Minnesota, one-third to one-half of all the assisted living discharge cases handled by the Ombudsman Program fall into this category; most involved wandering behavior. The Washington State Ombudsman noted that there is a lower bar for disruptive behavior in assisted living facilities than in nursing homes. Typical of many states, in Washington, the term "disruptive behavior" is loosely applied. Residents who need walkers or canes, who drool at dinner or who have occasional verbal outbursts might be considered disruptive and may be threatened with discharge. The Oregon State Ombudsman concurs, noting that a resident might be discharged for being too loud, aggressive or demanding.

Case example: Ombudsman intervention to prevent involuntary discharge in Minnesota *The wife of a couple living in assisted living was alert but wheelchair dependent; her husband was ambulatory, but suffered from memory loss. He began to wander. After one or two incidents of wandering out of the facility, the building manager became concerned and an eviction notice was issued. After an investigation, the Ombudsman arranged for a family meeting to be held in the facility, including the couple's assisted living service providers, Adult Protective Services, and the Ombudsman. A multi-point, mutually agreeable outcome was negotiated that included putting a door chime on the apartment door to signal the wife when the husband left the apartment after bedtime, and increasing the hours of home care services to monitor the husband during the evening hours until bedtime. As a result, the eviction notice was rescinded.*

Medication Administration

The Ombudsmen we talked with said that medication administration is a significant problem leading to discharge. Sometimes the problem may concern a specific type of medication such as injectables or controlled substances; in other instances, the concern is with the qualifications of the person who administers medications. Washington, like many other states, does not allow medication administration by non-nurses. All medications must be stored in a locked cabinet and may be delivered to residents for self-administration. For Medicaid-waiver residents, nurses may delegate administration of "non-invasive" medications (e.g., oral medications, topical ointments and drops). Under delegation, a registered nurse is required to train a staff aide to administer a particular medication to a specific resident; delegation does not carry over to other residents. In Minnesota, medication administration may be delegated for any assisted living resident, not just residents in the Medicaid waiver. The delegation is resident-specific and does not include injectables, except insulin.

Case example: Intervention in an involuntary discharge case regarding medication in Georgia *In a large personal care home in greater metropolitan Atlanta, a resident was prescribed Haldol to be taken as needed (prn) for anxiety.⁷ The facility determined that this medication constituted a chemical restraint and with the backing of the regulatory agency, presented a discharge notice to the resident. The reason given for discharge was that residents requiring physical or chemical restraints are not appropriate for the personal care home setting since all residents must be able to vacate the facility in an emergency with minimal assistance. The Ombudsman had discussions with a private attorney hired by the family about whether Haldol is, per se, a chemical restraint. The attorney appealed the discharge. An Administrative Law Judge decided that Haldol was not a chemical restraint and that this was an inappropriate discharge. As a result, the resident was able to stay in the facility and use Haldol as needed.*

⁷ In Georgia, regulations permit staff (non-nurses) to assist residents with medication administration.

Non-Payment

Discharge for non-payment may occur when a private-pay resident runs out of resources or falls behind in paying the monthly bill. The Michigan State Ombudsman says that payment related issues are involved in all the assisted living discharge cases handled by the program.

States that use Medicaid funds to pay for assisted living typically permit facilities to decide whether or not they will participate in the program. Thus, even if the state has an approved Medicaid waiver that covers assisted living, the number of providers that accept Medicaid may be small. In Washington State, according to the Ombudsman, statutory recognition of “discrimination by payment source” applies only to nursing homes, allowing boarding homes, in effect, to choose whether or not to accept Medicaid payment. Eighty percent of residents in boarding homes in Washington are private pay.

Consumer Protections for Involuntary Discharges

Notice

Among the states responding to the survey and the six states we interviewed, the period required for notice of transfer or discharge from an assisted living facility ranges from as little as 5 days up to 30 days; some states’ regulations do not specify a notice requirement at all. In states that do require written notice of discharge, the notice often does not contain critical information that might help the resident or family exercise their rights and effectuate a smooth transition. The resident, or most often the family, is left at a loss for finding another placement. (The charts on pages 15 and 16 outline discharge procedures in the six states we interviewed.)

Case example: Ombudsman intervention to ensure a smooth transition in a case of involuntary discharge in Georgia *A nurse came in regularly to oversee the care provided to an assisted living resident, whose care was paid for under a Medicaid waiver program. The regulatory agency made a determination that the care needs of this resident were too heavy for the facility to provide and required the resident to be discharged immediately to his home. The Ombudsman protested this decision vigorously, knowing that there was no care provider at home to supply the necessary care. After the Ombudsman’s intervention, the regulatory agency allowed the resident to return to the assisted living facility, but required the facility to seek nursing home placement for this resident. The Ombudsman Program assisted the facility and the resident to find a suitable placement and make a smooth transition.*

- In Oregon, state law provides discharge protections to residents in ALFs similar to those provided residents of nursing homes, including a 30 day written notice of transfer or discharge and requirements that the written notice

include: the reason for transfer/discharge, the effective date of the discharge/transfer, the location to which the resident is to be transferred or discharged, a statement of the right to appeal, and the name, address, and telephone number of the Ombudsman Program. The presumption on which Oregon's rules are based is that the resident will stay in the facility unless the ALF demonstrates an inability to provide needed services.

- Washington's regulations take a similar approach, requiring boarding homes to "make reasonable attempts to accommodate" the resident's needs. Washington has also adopted a "universal bill of rights" based on OBRA, providing the same rights to residents of boarding homes and nursing homes.

Assisted Living Discharges	State					
	CO	GA	MI	MN	OR	WA
Notice Requirements:						
▪ Written Notice Required	✓	✓	✓	✓	✓	✓
▪ Amount of Notice Required ⁸	30 days	30 days		"reason-able" ⁹	14 – 30 days ¹⁰	30 days
▪ Notice must provide Ombudsman Program contact information				✓ ¹¹	✓	

Appeals

Three of the six State Ombudsmen we interviewed – in Georgia, Oregon and Washington – report that their assisted living regulations specify an appeals process for assisted living residents who are involuntarily discharged. However, the appeals process itself may not provide adequate consumer protections. Georgia, for example, has an appeals process but the regulations do not require or specify reasons for discharging residents from ALFs. This leaves residents with a right to appeal an involuntary discharge but little substance on which to base an appeal. Oregon's appeal process is available to all residents regardless of payment source, while in Washington, the right to appeal discharges applies only to residents whose services are paid by Medicaid.

Georgia's regulations permit the regulatory agency to grant a waiver of a specific requirement when an assisted living facility wants to continue providing care to a specific resident who would otherwise be discharged, and the resident also wants to remain in the facility. This provision allows some residents to avoid an involuntary discharge altogether.

⁸ Most state regulations provide an exception to notice requirements when there is a danger to self or others or a medical emergency.

⁹ "Reasonable notice" applies to service termination. In Minnesota, landlord tenant law applies to an eviction from the housing unit. It requires a written notice from the landlord of 30 days plus a day.

¹⁰ Oregon's *Involuntary Move-Out Criteria and Notice of Move-Out* form are provided in Appendix I.

¹¹ There is no requirement to provide Ombudsman Program information in a written notice of eviction from the housing unit

Assisted Living Discharges	State		
	GA	OR	WA
Appeal Rights:			
▪ Time frame for filing an appeal	Not addressed	Not addressed	30 days
▪ Resident has right to stay in facility during appeal	✓	✓	✓
▪ Ombudsman has helped consumers file assisted living appeals	✓		

Practical Steps:

Whether the state's assisted living regulations provide specific consumer protections for residents to appeal involuntary discharges or not, the following are suggested ways Ombudsman Programs can work to help assisted living consumers protect their rights and ensure that ALFs provide quality services appropriate to residents' needs.

- Ombudsmen should develop relationships with assisted living providers, the regulatory agency, APS, and other agencies that go into assisted living facilities. In some states where there is no statutory requirement for notice of discharge, the facility or other agencies notify the Ombudsman Program of an imminent discharge, thus permitting the Ombudsman to intervene before discharge occurs and attempt to negotiate a satisfactory solution.
- Where there is no formal appeals process, Ombudsmen may still intervene to bring the parties together for discussion/negotiation to address the issues that lead to the issuance of a discharge notice.
- In addition to state regulations regarding discharges from assisted living, State Ombudsmen may want to check the applicability of landlord-tenant law to assisted living facilities in their states.¹²
- When discharge cannot be averted:
 - The Ombudsman may assist residents and families to secure another placement, by helping them assess their care needs and identifying settings where their needs can best be met.
 - The Ombudsman may be able to "buy time" negotiating with the facility and/or regulatory agency to ensure the resident is able to remain in place while a new placement decision is being made.
 - The Ombudsman should, when appropriate, refer the resident/family to legal services.

¹² See Appendix G, "Consumer Issues in Assisted Living," pp. 7-9, for a listing of statutory protections that may be applied to assisted living.

- Ombudsman Programs may want to develop state-specific training for providers on:
 - How to identify resident's needs.
 - Consumers' rights with regard to discharge and appeals.

- Ombudsman Programs may want to develop state-specific brochures and other informational materials for consumers on:
 - Assisted living discharges and residents' rights to information, assistance and due process in involuntary discharges.
 - Questions to ask when choosing an assisted living facility focusing on identifying whether the ALF has sufficient, trained staff to meet residents' current and changing care needs.
 - What needs to be addressed in the assisted living contract, to help residents and families protect their rights and choose an assisted living setting that is able to meet their current and changing needs. (Colorado publishes a guide to help consumers understand what needs to be covered in such contracts. See *Contracting for Board and Care*, Appendix F.)

- Ombudsmen may want to advocate for changes in the state's assisted living regulations to correct problems with involuntary discharge the program has handled. Consumer rights protections may be strengthened by measures such as:
 - Specifying in the regulation the conditions under which involuntary discharge may be permitted.
 - Adopting regulatory language that creates a presumption that the resident will be permitted to stay in the ALF unless the facility demonstrates an inability to meet the resident's needs, similar to the Oregon and Washington regulations.
 - Adopting a measure similar to the Georgia regulation that permits the regulatory agency to grant a waiver to an ALF that is willing and able to meet the needs of a particular resident who would ordinarily be required to move to a higher level of care under the regulations.
 - Ensuring that assisted living residents have at least the same protections in an involuntary discharge as are provided to nursing homes residents under OBRA, including the right to have an appeal hearing; to be given adequate (at least 30 days) written notice; and to receive assistance with finding alternative placement.

Summary

Ombudsman Program involvement in assisted living varies from state to state. State Ombudsmen interviewed for this paper generally agree that several challenges have limited their involvement in this arena, including: regulations and settings that make it difficult to reach assisted living residents; limited program resources; and a limited knowledge about the Ombudsman Program on the part of both consumers and providers

of assisted living. In addition, because of consumers' limited knowledge of assisted living and regulations that may not provide specific consumer protections, Ombudsman Programs' primary advocacy work in assisted living has centered around issues of discharge or the threat of discharge.

As assisted living becomes an increasingly popular option for consumers, there will be a corresponding need for Ombudsmen to conduct outreach to educate residents and providers about the program and to look for practical ways to become involved in assisted living advocacy at the state level. Ombudsman Programs that have begun to tackle these challenges offer promising practices that may be adopted by other programs to improve their outreach and advocacy assistance on behalf of assisted living consumers.

APPENDICES

- Appendix A Survey: Assisted Living Discharge Issues in Your State
- Appendix B Interview Questions for In-depth Look at Assisted Living Discharge Issues
- Appendix C Oregon Office of the Long-Term Care Ombudsman: Policy/Procedure #201
- Appendix D Excerpts from Georgia LTCO Training Manual 1998:
- Remedies for Residents of Personal Care Homes
 - Remedies for Residents of Personal Care Homes Act
 - Personal Care Homes: Rules and Regulations – Chapter 290-5-35
 - Personal Care Home Visitation Form
 - Personal Care Home Assessment
- Appendix E Admission Agreements and Residents' Rights in Washington State
- Appendix F Colorado Pamphlet: *Contracting for Board and Care*
- Appendix G Outline: *Consumer Issues in Assisted Living* by Stephanie Edelstein and Deanne Loonin (Fall 1999; updated March 2000)
- Appendix H King County LTC Ombudsman Program: *Residents' Preferences and Choices in Adult Family Homes*
- Appendix I Oregon's Assisted Living Facilities Administrative Rules: Involuntary Move-Out Criteria; Notice of Move-Out

APPENDIX A

SURVEY

ASSISTED LIVING DISCHARGE ISSUES IN YOUR STATE

1. What kind of information would you like to see included in a technical assistance paper on Assisted Living discharges? Please check all that apply:

- A. Case examples _____
- B. Policies and procedures from other programs _____
- C. Other states' statutes or regulations _____
- D. Examples of systemic advocacy in assisted living _____
- E. Other (Please explain) _____

2. Do your state's Assisted Living regulations address the following:

- A. Ombudsman access to assisted living residents and records _____
- B. Aging in place _____
- C. Discharge procedures _____
- D. Residents rights _____
- E. Appeals procedures _____

Please send us the statute or relevant sections of the regulations for items checked above

3. Appeals:-

- A. Does the state's regulation require that residents get a written notice of discharge? * ☐ YES ☐ No
- B. Does the state's regulation require that residents get a written notice before being relocated within the facility? * ☐ YES ☐ No

* How many days of written notice are required?

- A. _____
- B. _____

- C. Do residents have the right to appeal discharges? ☐ YES ☐ No
- D. Do residents have the right to appeal relocation within the facility? ☐ YES ☐ No
- E. Can residents stay in the assisted living facility during the appeal process? ☐ YES ☐ No

4. Has the Ombudsman program developed consumer education materials on Assisted Living? ☐ YES ☐ NO

Do they include the following?
(Check all that apply):

- ____ A. Advice on issues that need to be addressed in the assisted living contract, such as aging in place and discharge rights
- ____ B. Residents' rights in assisted living
- ____ C. How to get problems resolved in an assisted living facility
- ____ D. The Ombudsman Program's advocacy role in assisted living

Please share a copy of relevant materials with us.

5. Has your program handled assisted living cases involving the following?
(Check all that apply):

- | | | | |
|----|---------------------------|------------------------|-------|
| A. | Disruptive behavior | (approx. # in FY 1999) | _____ |
| B. | Medication administration | (approx. # in FY 1999) | _____ |
| C. | Discharges | (approx. # in FY 1999) | _____ |
| D. | Appeals | (approx. # in FY 1999) | _____ |

6. Please list any other states we should contact

APPENDIX B

INTERVIEW QUESTIONS FOR IN-DEPTH LOOK AT ASSISTED LIVING DISCHARGE ISSUES
3/20/2000

1. We would like to discuss specific complaints your program has handled where the following issues were key factors in involuntary assisted living discharges:

- Disruptive behavior
- Medication administration
- Other significant issues involved in involuntary discharges

In describing the complaints, please try to answer the following questions:

- ✓ Were other players involved, e.g., licensing agency, advocacy organization, legal services, etc.?

- ✓ What was the outcome?

- ✓ Was the handling of this issue in an assisted living facility any different than the handling of similar issues in a nursing home? How was it different?

2. For states that provide an appeal process for assisted living discharges

- Has the Ombudsman Program been involved in such appeals?
- Please describe a case and how it was handled.

3. Is there a systemic problem underlying assisted living discharges in your state such as:
- State regulations regarding who can be served in assisted living? Please explain.
 - Lack of appeal rights or inadequate appeal process for assisted living residents? Please explain
 - Inadequate funding for Ombudsman work in assisted living (e.g., no/few volunteers, limited staff time available, limited outreach)? Please explain.
 - Other? Please explain.
4. Do you have policies and procedures specific to Ombudsman complaint handling in assisted living facilities? (If yes, please send copy.)
5. If you follow complaint-handling procedures used in nursing homes, are any modifications needed to address assisted-living-specific cases? Please describe.
6. What kinds of technical assistance on assisted living discharge issues would be most useful to you?

APPENDIX C



Office of the Long-Term Care Ombudsman Policy/Procedure

Policy/Procedure # 201

Subject: Implementing the Buddy System

RATIONALE:

Certified volunteers work in an extremely complex and often difficult environment. Their primary job is to solve problems for or on behalf of residents. This is not an easy task under many circumstances. In fact, the ombudsman job has been called "one of the most difficult in the field of aging." The certified volunteer may be further challenged by tension and conflict from a defensive or hostile provider. Misunderstanding, fear, or a lack of knowledge about the ombudsman role, mission, philosophy and legal authority may shape provider attitudes.

The risk for problems is especially high when certified volunteers work alone. Conflict, especially with a defensive provider, or one not familiar with the program, can leave the lone certified volunteer's actions vulnerable to misinterpretation or even false accusation. This pits the certified volunteer's word against the provider's — a recipe for disaster — not just for the involved certified volunteer, but for the program as a whole.

This policy establishes guidelines for the implementation of the buddy system in all types of long-term care facilities when certain risks are identified. The buddy system also offers the provider accountability for certified volunteer adherence to program policies and procedures.

P/P # 201 Implementing the Buddy System

- I. The buddy system employs two certified volunteers working in tandem in a facility. The volunteers must stick together at all times when visiting the facility in order to serve and protect individual ombudsman integrity.

The buddy system presents the following benefits:

- A. Another witness to the conduct of the certified volunteer.
 - B. A second witness to the behavior of the caregiver.
 - C. A second investigative witness.
 - D. An opportunity to model and/or observe good certified volunteer behavior and receive feedback.
 - E. An opportunity to directly share the certified volunteer experience with a colleague.
- II. Certified volunteers must initiate the buddy system under the following conditions:
- A. The certified volunteer encounters a hostile, argumentative or highly defensive caregiver.
 - B. The certified volunteer encounters an adult foster care home with serious problems, or with issues likely requiring complex and difficult problem-solving.

In either of these situations:

- 1. The certified volunteer must cease visiting the facility. He or she will **immediately** contact a deputy to report a need for buddy system implementation.
 - 2. The deputy will assist the certified volunteer in identifying a pool of certified volunteers to accompany the certified volunteer pursuant to II. A-B above. It is not appropriate to "buddy" with anyone other than another certified volunteer.
 - 3. If no certified volunteer "buddy" is available, the notifying certified volunteer will not visit the home until the certified volunteer and deputy agree to a plan to provide ombudsman services to the facility in question.
- III. A deputy may require a "buddy" in situations that may come to his/her attention when information suggests that the conditions in II. A or II. B have been met.

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- IV. In situations where a "buddy" is required, the buddy system will remain in effect until the certified volunteer and the deputy conclude that positive, safe and productive program/provider relations have been (re)established.
- V. Certified volunteers are encouraged to work together in teams for any reason. However, the specific purpose and protocol for implementation of the buddy system distinguishes it from other models of certified volunteers working together.

APPENDIX D

REMEDIES FOR RESIDENTS OF PERSONAL CARE HOMES

The Remedies for Residents of Personal Care Homes Act of 1994 provides remedies for personal care home residents whose rights have been violated by the personal care home. Residents may choose from the following remedies:

Informal Grievance -- a resident or representative may either tell or write to the facility manager and describe the grievance. Within five (5) days, the manager must either resolve the grievance to the resident's satisfaction or respond in writing, including a list of the other remedies available to the resident.

Administrative Hearing -- a resident or representative or the state or community ombudsman may request a hearing before a DHR hearing officer if they believe the resident's rights have been violated by the personal care home. DHR must conduct the hearing within 45 days. In cases where the provider is accused of retaliation, DHR must hold the hearing within 15 days.

Private Cause of Action -- a resident or representative or the Attorney General (upon DHR's request) may bring a law suit for damages. Where a violation is found by the court, actual damages or \$1000, whichever is greater, shall be awarded. Punitive damages may be awarded as well.

Injunctive Relief -- a resident or representative or the Attorney General (upon DHR's request) may bring a law suit to enjoin a personal care home from violating the rights of a resident.

Mandamus Action -- a resident or representative, the community ombudsman, the governing body of the personal care home, or any other interested party may bring an mandamus action against DHR asking the court to order DHR to comply with state or federal laws related to the operation of a personal care home or the care of its residents.

The Act does not list the rights it describes but, instead, refers to all of the rights listed in the Personal Care Home regulations (Rules of the Department of Human Resources Chapter 290.5-35), including protections relating to admission, transfer, or discharge of residents. The Act can be found at O.C.G.A. § 31-8-130 *et seq.*

For more information regarding this Act, you may contact the State Long-term Care Ombudsman Program at 404/657-5319 or your community ombudsman.

Remedies for Residents of Personal Care Homes Act

O.C.G.A. § 31-8-130. Short title.

This article shall be known and may be cited as the "Remedies for Residents of Personal Care Homes Act."

O.C.G.A. § 31-8-131. Legislative findings and intent.

The General Assembly finds that persons residing within personal care homes are often isolated from the community and often lack the means to assert fully their rights as individual citizens. The General Assembly also recognizes that in order for the rights of residents of personal care homes to be fully protected, residents must be afforded a means of recourse when such rights have been denied. It is therefore the intent of the General Assembly to preserve the dignity and personal integrity of residents of personal care homes by providing access to a legal process to hear and redress the grievances of such residents regarding their individual rights.

O.C.G.A. § 31-8-132. Definitions.

As used in this article, the term:

- (1) "Administrator" means the manager designated by the governing body of a personal care home as responsible for the day-to-day management, administration, and supervision of the personal care home, who may also serve as on-site manager and responsible staff person except during periods of his or her own absence.
- (2) "Community ombudsman" means a person certified as a community ombudsman pursuant to Code Section 31-8-52.
- (3) "Governing body" means the board of trustees, the partnership, the corporation, the association, or the person or group of persons who maintain and control a personal care home and who are legally responsible for the operation of the home.
- (4) "Legal surrogate" means a duly appointed person who is authorized to act, within the scope of the authority granted under the legal surrogate's appointment, on behalf of a resident who is adjudicated or certified incapacitated. No member of the governing body, administration, or staff of a personal care home or any affiliated personal care home or their family members may serve as the legal surrogate for a resident.
- (5) "Personal care home" or "home" means a facility as defined in Code Section 31-7-12.

(6) "Representative" means a person who voluntarily, with the resident's written authorization, may act upon the resident's direction with regard to matters concerning the health and welfare of the resident, including being able to access personal records contained in the resident's file and receive information and notices pertaining to the resident's overall care and condition. No member

of the governing body, administration, or staff of a personal care home or any affiliated personal care home or their family members may serve as the representative for a resident.

(7) "Resident" means a person who resides in a personal care home.

(8) "State ombudsman" means the state ombudsman established under Code Section 31-8-52.

O.C.G.A. § 31-8-133. Residents' Rights.

Residents' rights shall include all rights enumerated in the Rules of the Department of Human Resources Chapter 290-5-35, including, but not limited to, procedural protections relating to admission, transfer, or discharge of residents.

O.C.G.A. § 31-8-134. Grievance procedure.

(a) Any resident, or the representative or legal surrogate of the resident, if any, who believes his or her rights under this article have been violated by a personal care home or its governing body, administrator, or employee shall be permitted to file a grievance under this Code section.

(b) In order to file the grievance provided for in subsection (a) of this Code section, the resident, or representative or legal surrogate of the resident, if any, may submit an oral or written grievance to the administrator or the administrator's designee. The administrator or designee, within five business days, shall either resolve the grievance to the grievant's satisfaction or respond in writing to the grievance, including in the response a description of the review and appeal rights set forth in this article.

(c) If the person filing the grievance is not satisfied by the action or failure to act of the administrator or designee, the grievant may submit an oral or written complaint to the state or community ombudsman.

O.C.G.A. § 31-8-135. Hearing; transfer of resident.

(a) Any resident, the representative or legal surrogate of the resident, if any, or the state or community ombudsman, who believes the resident's rights have been violated by a personal care home, its governing body, administrator, or employee, shall have the right to request a hearing from the department pursuant to Chapter 13 of Title 50, the "Georgia Administrative Procedure Act."

(b) No person shall be prohibited from requesting a hearing pursuant to subsection (a) of this Code section for failure to exhaust any rights to other relief granted under this article.

(c) (1) Except as provided in paragraph (2) of this subsection, the hearing provided for in subsection (a) of this Code section shall be conducted within 45 days of the receipt by the department of the request for a hearing. Where the state or community ombudsman has not already been involved in the matter at issue, the department may refer the request for a hearing to the state or community ombudsman for informal solution pending the hearing. Such referral shall not extend the 45 day period in which the department shall conduct such hearing.

(2) If a resident or a resident's legal surrogate or representative, if any, alleges that an action or failure to act by a personal care home or its governing body, administrator, or employee is in retaliation for the exercise by that resident or his or her representative or legal surrogate, if any, of a right conferred by state or federal law or court order, the hearing provided for in subsection (a) of this Code section shall be conducted within 15 days of the receipt of the department of the request for a hearing. For such hearing, all pending requests for hearing by the resident or his or her legal surrogate or representative, if any, relating to such resident shall be consolidated.

(d) No transfer of a resident shall take place until all appeal rights are exhausted, unless:

(1) An immediate transfer is necessary because the resident develops a physical or mental condition requiring continuous medical or nursing care; or

(2) The resident's continuing behavior or condition directly and substantially threatens the health, safety, and welfare of the resident or any other resident.

(e) The department shall hold any hearing provided for in subsection (a) of this Code section at the personal care home upon the resident's request or as necessary due to the resident's physical condition. Where two or more residents of a personal care home allege a common complaint, the department may at the residents' request schedule a single hearing.

(f) If the department finds no violations of this article, the resident and personal care home will be so informed. If a violation has occurred:

(1) The hearing officer shall so notify the staff within the department responsible for the licensure of personal care homes;

(2) The department shall order the personal care home to correct such violation; and

(3) Upon failure of the personal care home to correct such violation within a reasonable time, the department may impose appropriate civil penalties as provided for in Code Section 31-2-6.

O.C.G.A. § 31-8-136. Action for damages.

(a) Any resident or the representative or legal surrogate of the resident, if any, may bring an action in a court of competent jurisdiction to recover actual and punitive damages against a personal care home or its governing body, administrator, or employee for any violation of the rights of a resident granted under this article. Upon referral and request by the department, the Attorney General may bring such an action. Where a violation of a resident's rights has been found, the resident shall be awarded the actual damages or \$1,000.00, whichever is greater, and may be awarded punitive damages.

(b) No person shall be prohibited from maintaining an action pursuant to this Code section for failure to exhaust any rights to administrative or other relief granted under this article.

(c) The right of a resident to bring an action pursuant to this Code section is in addition to any and all other rights, remedies, or causes of action the resident may have by statute or at common law.

(d) Any resident or the representative or legal surrogate of the resident, if any, may bring an action to recover damages for any action of a personal care home or its governing body, administrator, or employee that adversely affects the resident's rights, privileges, or living arrangement in retaliation for that resident or his or her representative or legal surrogate, if any, having exercised a right conferred by state or federal law or court order. Upon referral and request by the department, the Attorney General may bring such an action. In any action brought under this Code section alleging retaliation, there shall be a presumption of retaliatory conduct, rebuttable by a showing of clear and convincing evidence, if an owner, licensee, administrator, or employee attempts to discharge, transfer, or relocate a resident involuntarily within six months after that resident or his or her representative or legal surrogate, if any, files an action for relief under this Code section, exercises a right to a hearing under this article, or makes an oral or written grievance against the personal care home or its governing body, administrator, or employee to the personal care home, a state or community ombudsman, or a state government official or employee.

(e) Code Section 31-5-8 shall apply fully to any willful violation of this article.

O.C.G.A. § 31-8-137. Temporary restraining order; injunctions.

A resident, the representative or legal surrogate of the resident, if any, or the Attorney General may bring an action in a court of competent jurisdiction for a temporary restraining order, preliminary injunction, or permanent injunction to enjoin a personal care home from violating the rights of a resident.

O.C.G.A. § 31-8-138. Failure to validly license as defense.

The failure of the governing body to obtain or maintain a valid license to operate a personal care home shall not constitute a defense to any action brought pursuant to this article where the facility at issue is subject to licensure as a personal care home.

O.C.G.A. § 31-8-139. Mandamus.

A resident, the representative or legal surrogate of the resident, if any, the community ombudsman, the governing body of the personal care home, or any other interested party may bring an action in court for mandamus pursuant to Article 2 of Chapter 6 of Title 9 to order the department to comply with any state or federal law relevant to the operation of a personal care home or the care of its residents.

Personal Care Homes

Rules and Regulations – Chapter 290-5-35

290-5-35-.01 Authority.

The legal authority for this Chapter is Sec. 31-2-4 and Chapter 7 of Title 31 of the Official Code of Georgia Annotated.

Authority Ga. L. 1964, pp. 499, 513, 611; Ga. L. 1969, pp. 715, 716; Ga. L. 1973, pp. 635, 637; Ga. L. 1978, p. 1757; O.C.G.A. Secs. 31-2-4, 31-7-2.1., 31-7-12, 31-7-250. History. Original Rule entitled "Definitions" was filed on May 21, 1979; effective June 11, 1979, as specified by the Agency.

Amended: Filed January 6, 1981; effective February 6, 1981, as specified by the Agency. Repealed: New Rule entitled "Authority" adopted. F. Oct. 22, 1993; eff. Nov. 11, 1993.

290-5-35-.02 Purposes.

The purposes of these rules and regulations are to establish the minimum standards for the operation of homes which provide residential services to the citizens of this State who require varying degrees of supervision and care and to assure safe, humane and comfortable supportive residential settings for adults who need such services.

Authority Ga. L. 1964, pp. 499, 513, 612; O.C.G.A. Secs. 31-2-4, 31-7-2.1., 31-7-12. History. Original Rule entitled "Governing Body" was filed on May 21, 1979; effective June 11, 1979, as specified by the Agency. Amended: Filed January 6, 1981; effective February 6, 1981, as specified by the Agency. Repealed: New Rule entitled "Purposes" adopted. F. Oct. 22, 1993; eff. Nov. 11, 1993.

290-5-35-.03 Exemptions.

These regulations do not apply to the following facilities:

- (a) Boarding homes or rooming houses which provide no personal services other than lodging and meals;
- (b) Facilities offering temporary emergency shelter, such as those for the homeless and victims of family violence;
- (c) Treatment facilities which provide medical and nursing services and which are approved by the state and regulated under other more specific authorities;
- (d) Facilities providing residential services for federal, state or local correctional institutions under the jurisdiction of the criminal justice system;
- (e) Hospices which serve terminally ill persons as defined in O.C.G.A. Sec. 31-7-172(3);
- (f) Therapeutic substance abuse treatment facilities which are not intended to be an individual's permanent residence;
- (g) Group residences organized by or for persons who choose to live independently or who manage their own care and share the cost of services including but not limited to attendant care, transportation, rent, utilities and food preparation; or
- (h) Charitable organizations providing shelter and other services without charging any fee to the resident.

Authority Ga. L. 1964, pp. 499, 612; O.C.G.A. Secs. 31-2-4, 31-7-2.1., 31-7-12. History. Original Rule entitled "Administration" was filed on May 21, 1979; effective June 11, 1979, as specified by the Agency. Amended: Filed

January 6, 1981; effective February 6, 1981, as specified by the Agency. Repealed: New Rule entitled "Exemptions" adopted. F. Oct. 22, 1993; eff. Nov. 11, 1993.

290-5-35-.04 Definitions. Amended.

Unless otherwise defined by specific sections as used in these rules and regulations the term:

- (a) "Activities of daily living" means bathing, shaving, brushing teeth, combing hair, toileting, dressing, eating, laundering, cleaning room, managing money, writing letters, shopping, using public transportation, making telephone calls, grooming, obtaining appointments, engaging in leisure and recreational activities, or other similar activities;
- (b) "Administrator" means the manager designated by the Governing Body as responsible for the day-to-day management, administration and supervision of the Personal Care Home, who may also serve as on-site manager and responsible staff person except during periods of his or her own absence;
- (c) "Ambulatory Resident" means a resident who has the ability to move from place to place by walking, either unaided or aided by prosthesis, brace, cane, crutches, walker or hand rails, or by propelling a wheelchair; who can respond to an emergency condition, whether caused by fire or otherwise, and escape with minimal human assistance such as guiding a resident to an exit, using the normal means of egress;
- (d) "Chemical Restraint" means a psychopharmacologic drug that is used for discipline or convenience and not required to treat medical symptoms;
- (e) "County" authorized representatives;
- (f) "Criminal Records Check" means the satisfactory criminal records check determination which must be on file with the Department for all administrators and staff pursuant to the requirements of O.C.G.A. Sections 31-7-250 et seq.;
- (g) "Department" means the Department of Human Resources of the State of Georgia;
- (h) "Governing Body" means the Board of Trustees, the partnership, the corporation, the association, or the person or group of persons who maintain and control the home and who are legally responsible for the operation of the home;
- (i) "Legal Surrogate" means a duly appointed person who is authorized to act, within the scope of the authority granted under the legal surrogate's appointment, on behalf of a resident who is adjudicated or certified incapacitated. The legal surrogate may act on a resident's behalf where a resident has not been adjudicated as incapacitated provided that the action is consistent with the resident's wishes and intent and is within the scope of the authority granted. Where such authority is exercised pursuant to a Power of Attorney executed by a resident, the facility must maintain a copy of this document in the resident's files. The resident's duly appointed legal surrogate(s) shall have the authority to act on the resident's behalf as established by written applicable federal and state of Georgia law, and shall be entitled to receive information relevant to the exercise of his or her authority. No member of the governing body, administration, or staff of the personal care home or affiliated personal care homes or their family members may serve as the legal surrogate for a resident;
- (j) "Medical services" means services which may be provided by a person licensed under the Medical Practice Act O.C.G.A. 43-34-20 et seq.;
- (k) "Non-Family Adult" means a resident 18 years of age or older who is not related by blood within the third degree of consanguinity or by marriage to the person responsible for the management of the personal care home or to a member of the governing body;
- (l) "Nursing services" means those services which may be rendered by a person licensed under the Nurse Practice Act of O.C.G.A. 43-26-1 et seq.;

290-5-35-.15 Admission. Amended.

(1) Criteria for admission to a home are as follows:

(a) Persons admitted to a personal care home must be at least 18 years of age;

(b) The home shall admit or retain only ambulatory residents;

(c) The home shall not admit, or retain persons who require the use of physical or chemical restraints, isolation, or confinement for behavioral control;

(d) Persons admitted to a home may not be confined to bed and may not require continuous medical or nursing care and treatment;

(e) Medical, nursing, health or supportive services required on a periodic basis, or for short-term illness, shall not be provided as services of the home. When such services are required, they shall be purchased by the resident or the resident's representative or legal surrogate, if any, from appropriately licensed providers managed independently for the home. The home may assist in arrangement for such services, but not provision of those services.

(2) No home shall admit or retain a resident who needs care beyond which the facility is permitted to provide. Applicants requiring continuous medical or nursing services shall not be admitted or retained.

(3) The administrator or on-site manager of a home shall conduct an interview with the applicant and/or representative or legal surrogate, if any, of the applicant to ascertain that the home can meet the applicant's needs. The administrator or on-site manager shall require the applicant to provide the home with a licensed physician's report of a physical examination dated within 30 days prior to the date of admission. A resident admitted pursuant to an emergency placement made by the Adult Protective Services Section of the Department of Family and Children Services shall receive a physical examination within 14 days of the emergency admission. The following information is required:

(a) The signature, address, and telephone number of the examining physician;

(b) A description of physical and mental health status including diagnosis and any functional limitation;

(c) Recommendations for care including medication, diet, and medical, nursing, health, or supportive services which may be needed on a periodic basis;

(d) A statement that, on the day the examination is given:

1. Continuous 24 hour nursing care is not needed;

2. The person's needs can be met in a facility that is not a medical or nursing facility;

3. The person has received screening for tuberculosis and has no apparent signs or symptoms of infectious disease which is likely to be transmitted to other residents or staff;

4. The person may need personal assistance with some activities of daily living.

(e) If the above information is not contained in the report of the physical examination, the administrator or on-site manager shall obtain the above information from the resident's physician. Such information shall be recorded in the resident's file. In the event a resident develops a significant change in physical or mental condition, the governing body shall be required to provide the Department, upon request, with a current physical examination from a physician indicating the resident's continued ability to meet the requirements of the home.

Authority Ga. L. 1964, pp. 499, 612; O.C.G.A. Secs. 31-2-4, 31-7-2.1. History. Original Rule entitled "Water and Sanitation" was filed on May 21, 1979; effective June 11, 1979, as specified by the Agency. Repealed: New Rule

- (9) A home shall maintain records of all menus as served. Menus shall be kept on file for thirty days for review by the Department.
- (10) A minimum of one individual qualified by training or by experience and performance shall be responsible for food preparation. Additional food service staff, including relief persons necessary for regular and timely meals, shall be employed.
- (11) A home shall arrange for special diets as prescribed.

Authority Ga. L. 1964, pp. 499, 518, 612, 613; O.C.G.A. Secs. 31-2-3, 31-7-2.1. History. Original Rule entitled "Inspections" was filed on May 21, 1979; effective June 11, 1979, as specified by the Agency. Amended: Rule repealed and a new Rule of same title adopted. Filed January 6, 1981; effective February 6, 1981, as specified by the Agency. Repealed: New Rule entitled "Nutrition" adopted. F. Oct. 22, 1993; eff. Nov. 11, 1993.

290-5-35-.21 Procedures for Change in Resident Condition.

- (1) In case of an accident or sudden adverse change in a resident's condition or adjustment, a home shall immediately obtain needed care and notify the representative or legal surrogate, if any. A record of such incidents shall be maintained in the resident's files.
- (2) Immediate investigation of the cause of an accident or injury involving a resident shall be initiated by the administrator or on-site manager of the home and a report made to the representative or legal surrogate, if any, with a copy of the report maintained in the resident's file and in a central file.

Authority Ga. L. 1964, pp. 499, 513, 612, 613; O.C.G.A. Secs. 31-2-4, 31-7-2.1. History. Original Rule entitled "Waiver of Rules" was filed on May 21, 1979; effective June 11, 1979, as specified by the Agency. Amended: Rule repealed and a new Rule of same title adopted. Filed January 6, 1981; effective February 6, 1981, as specified by the Agency. Repealed: New Rule entitled "Procedures for Change in Resident Condition" adopted. F. Oct. 22, 1993; eff. Nov. 11, 1993.

290-5-35-.22 Death of a Resident.

- (1) Should a resident die while in the home, the administrator, on-site manager or designated staff shall immediately notify the resident's physician, the next of kin, and the representative or legal surrogate, if any. Statutes applicable to the reporting of sudden or unexpected death and reports which must accompany the deceased shall be observed.
- (2) Upon death of the resident, the home must refund to the representative or legal surrogate, if any, any security deposit made to the home by or on behalf of the resident in compliance with O.C.G.A. Section 44-7-30 et seq.

Authority Ga. L. 1964, pp. 499, 612; O.C.G.A. Secs. 31-2-4, 31-7-2.1. History. Original Rule entitled "Deemed Status" was filed on May 21, 1979; effective June 11, 1979, as specified by the Agency. Repealed: New Rule entitled "Death of a Resident" adopted. F. Oct. 22, 1993; eff. Nov. 11, 1993.

290-5-35-.23 Immediate Transfer of Residents. Amended.

- (1) The administrator or on-site manager of the home may initiate immediate transfer if the resident develops a physical or mental condition requiring continuous medical care or nursing care or if a resident's continuing behavior or condition directly and substantially threatens the health, safety and welfare of the resident or any other resident.

(2) In the event such immediate transfer is required, the administrator or on-site manager of the home shall advise both the resident and the resident's representative or legal surrogate, if any, and immediate arrangements shall be made based on the written admission agreement to transfer such resident to an appropriate facility. The administrator or on-site manager shall document in the resident's file the reasons for the transfer.

(3) Where immediate transfer is to be made pursuant to paragraphs (1) and (2), the administrator or on-site manager shall make arrangements for transfer in accordance with the admission agreement and shall transfer the resident to an appropriate facility where the resident's needs can be met. Prior to making such transfer, the administrator or on-site manager shall:

(a) Inform the resident and representative or legal surrogate, if any, of the reason for the immediate transfer;

(b) Inquire as to any preference of the resident and representative or legal surrogate, if any, regarding the facility to which the resident is to be transferred;

(c) Inform the representative or legal surrogate, if any, of the resident's choice regarding such transfer;

(d) Inform the resident and the representative or legal surrogate, if any, of the place to which the resident is to be discharged;

(e) Provide a copy of the resident file to the receiving facility within 24 hours of transfer; and

(f) Document in the resident's file the following:

1. the reason for the immediate transfer;

2. the fact that the resident and the representative or legal surrogate, if any, were informed pursuant to this paragraph; and

3. the name, address, and telephone number of the place to which the resident is to be transferred or discharged.

(4) Upon immediate transfer of the resident, the home must refund to the resident or representative or legal surrogate, if any, any security deposit made to the home by or on behalf of the resident in compliance with O.C.G.A. Section 44-7-30 et seq.

Authority Ga. L. 1964, pp. 499, 507, 513; O.C.G.A. Secs. 31-2-4, 31-7-2.1. History. Original Rule entitled "Reporting to the Department" was filed on May 21, 1979; effective June 11, 1979, as specified by the Agency Repealed: New Rule entitled "Immediate Transfer of Residents" adopted. F. Oct. 22, 1993; eff. Nov. 11, 1993. Amended: F. May 2, 1994; eff. Jul. 1, 1994, as specified by the Agency.

290-5-35-.24 Discharge or Transfer of Residents.

(1) Each admission agreement shall include a written procedure for handling discharge and transfer of the resident. The administrator or on-site manager shall contact the representative or legal surrogate, if any, when there is need for discharge or transfer of a resident. Each resident shall have the right to thirty days' written notice to both the resident and the representative or legal surrogate, if any, prior to discharge or transfer of the resident except where immediate transfer is required.

(2) In all cases except those requiring immediate transfer pursuant to Rule 290-5-35-.23 residents whose needs cannot be met by the home or who no longer choose to live in the home shall be discharged or transferred to an appropriate facility based on discharge and transfer procedures entered into at the time of admission. For such discharge or transfer, a thirty-day written notice shall be given to both the resident and representative or legal surrogate, if any, except when

transfer is necessitated by a change in physical or mental condition as defined in these rules or as authorized above in 290-5-35-.23 as an immediate transfer. Where there is no representative or legal surrogate or the representative or legal surrogate is unwilling to act, the administrator or on-site manager shall notify the Department of Family and Children Services for the county in which home is located and other appropriate agencies when transfer assistance is needed. The transferring facility shall provide a copy of the resident file to the receiving facility prior to or at the time of transfer.

(3) The Department may reassess the resident at anytime to determine whether a resident needs care beyond that which the facility is permitted to provide.

(4) Upon discharge or transfer of the resident, the home must refund to the resident or representative or legal surrogate, if any, any security deposit made to the home by or on behalf of the resident in compliance with O.C.G.A. Section 44-7-30 et seq.

Authority Ga. L. 1964, pp. 499, 513, 518, 611; Ga. L. 1969, pp. 715, 716; Ga. L. 1973, pp. 635, 637; Ga. L. 1977, pp. 309, 310; and Ga. L. 1978, p. 1757; O.C.G.A. Secs. 31-2-4, 31-7-2.1. History. Original Rule entitled "Enforcement" was filed on May 21, 1979; effective June 11, 1979, as specified by the Agency. Amended: Filed January 6, 1981; effective February 6, 1981, as specified by the Agency. Repealed: New Rule entitled "Discharge or Transfer of Residents" adopted. F. Oct. 22, 1993; eff. Nov. 11, 1993.

290-5-35-.25 Application for Permit. Amended.

(1) The governing body of each home shall submit to the Department an application for a permit to operate under these rules and regulations. No personal care home shall be operated and no residents admitted without such a permit which is current under these rules and regulations.

(2) The application for a permit shall be made on forms provided by the Department.

(3) A criminal record check application shall accompany applications.

(4) Each application for a permit shall be accompanied by a floor sketch of the home showing windows, doors, room measurements, and bed placement for residents, family and/or staff.

(5) A listing of the names of all staff, including the administrator or on-site manager, who will be working in the home, if known, shall be included with the application for a permit. This listing shall include the full name of each staff person, their assigned duties in the home, their birth date and Social Security Number. If such information is not known at the time of application, it must be provided to the Department within 30 days of issuance of a provisional permit.

(6) The ownership of the home shall be fully disclosed in its application for a permit. In the case of corporations, partnerships, and other bodies created by statute, the corporate officers and all other individuals or family groups owning ten percent or more of the corporate stock or ownership shall be disclosed in the application for a permit as well as the registered agent for service of process.

(7) All others shall submit a statement attesting to the name(s) and address(es) of each person owning any part of the facility.

(8) Local zoning and other local requirements regarding the proper location and establishment of homes shall be addressed by the applicant with the responsible local officials.

(9) Personal care homes are expected to comply with all applicable provisions of the Americans With Disabilities Act and Section 504 of the Rehabilitation Act of 1973 and federal regulations promulgated thereunder. Any violation of these statutes or regulations may be grounds for the department to initiate action for sanction against such homes.

Personal Care Home Visitation Form

PCH Home: _____

Date: _____

Ombudsman/Volunteer: _____

Is this a licensed home? Yes ☐ No ☐ Unsure ☐Address of PCH Home: _____

Telephone: _____ County: _____

Maximum Occupancy: _____ Present Occupancy: _____

Affiliated with State or County Program? Yes ☐ No ☐ Unsure ☐

If yes, Name of Program: _____

Contact Person: _____

Residents with disabilities that PCH will Accept:

☐ Mental Health ☐ Mentally Retarded ☐ Need of Wheelchair
AccessibilityGender Accepted: ☐ Male ☐ Female ☐ Both

Age Groups Accepted:

☐ Under age 25 ☐ 25 – 55 years ☐ over 55 years ☐ all ages

Cost for basic services per month? \$_____/month

Charges for extra services:

Meals Provided:

Breakfast ☐ Yes ☐ No
Lunch ☐ Yes ☐ No
Dinner ☐ Yes ☐ No
Snack ☐ Yes ☐ NoProvisions made for special diet? ☐ Yes ☐ No

24 hours supervision provided? ☐ Yes ☐ No

Trained Medical Personnel? ☐ Yes ☐ No

Type of training: _____

Medication Reminders ☐ Yes ☐ No

Making and reminding of appointments for medical checkups? ☐ Yes ☐ No

Signed copies of the Residents Bill of Rights? ☐ Yes ☐ No

Signed admission agreements? ☐ Yes ☐ No

Personal Care Home Assessment

Name of Home: _____

Address: _____

Part I – Questions to ask the Provider/Manager.

Name of Manager or Provider: _____

1. Do you have a license to operate? ☐ Yes ☐ No

If yes, for how many residents? _____

How many residents do you currently have? _____

2. List the names of residents:

3. Does the manager/provider live at the home? ☐ Yes ☐ No

Who are the employees?

Who is the employer?

4. Who is in charge when the manager/provider is not there?

5. Who owns the home?

Who owns the business?

If not the same person, who owns the property?

6. Can you produce evidence of first aid training? ☐ Yes ☐ No

7. Can you produce evidence of a criminal record check on all staff? ☐ Yes ☐ No

Part II. Questions for Residents.

Try to get the name and age of each resident that you talk to and conduct a brief personal conversation with each resident.

Examples of questions to ask:

- How long have you been here?
- Who is your family? (Name and addresses)
- Do they visit you here? How often?
- Where did you live before you came here?
- Who is your doctor?
- What type of medicine do you take?
- Who gives you your medicine?
- What are things you do everyday that you need help with?
- bathing? dressing? toileting?
- Where did you sleep last night? Can you show me your bed?
- Who pays for you care in this home?
- What did you have for breakfast and supper?
- Did you have enough to eat?
- What do you like most about the food?
- Do you and other residents go on "outings"? How frequently? Where do you go?
- Is there anything you would like to tell me about living in this home?

Part III. Observations/Assessment of the Physical Plant

1. Is the kitchen clean? ☐ Yes ☐ No

Is there food in the refrigerator or pantry? ☐ Yes ☐ No

Check the food supply to see if it is sufficient and appropriate.

2. Bathrooms.

Are toilets working? ☐ Yes ☐ No

Are the toilets clean? ☐ Yes ☐ No

Is there running hot/cold water? ☐ Yes ☐ No

Is the bath area clean? ☐ Yes ☐ No

3. Is there a file for each resident? ☐ Yes ☐ No

Do the file names match residents names? ☐ Yes ☐ No

4. If there are any residents who use wheelchairs, are their bedrooms on the ground floor? ☐ Yes ☐ No

5. Are there ramps in homes with residents who use wheelchairs?
☐ Yes ☐ No

6. Are any of the residents restrained? ☐ Yes ☐ No
If so, why and how? (Include isolated in room or area)

7. Check medicine names and match with current residents. Is any of the medicine expired? ☐ Yes ☐ No

8. Are medicines locked up? ☐ Yes ☐ No

Who has the key?

Is the key on the premises at all times? ☐ Yes ☐ No

9. Are there residents in the home that you feel could not perceive an emergency or evacuate in case of an emergency? ☐ Yes ☐ No

If yes, on what is your assessment based for each resident?

Resident's name: _____

Reason: _____

[illegible]

APPENDIX E

Admission Agreements and Residents' Rights in Washington State

I. Introduction

Over the last decade, the regulatory orientation towards long-term care facilities has increasingly become “outcomes” focused, as opposed to “paper compliance.” Overall, this has greatly benefited residents of facilities and helped us focus on things that matter to the residents’ well being.

However, some papers are still very important, such as the admission agreements signed by residents. These documents inform the residents of their rights and responsibilities. If the documents mis-inform them, most residents and their families will not know it. They won’t know, for example, that they could object to restrictive visiting rules, ask for a deposit refund, or protest a discharge. The net result is that some residents will be unable to assert their rights because they are unaware of them.

State law now expressly requires that all admission agreements used by long-term care facilities be consistent with state law, and that no facility can require *or request* a resident to sign any waiver of residents’ rights. RCW 70.129.105 and .150(2). This law applies to nursing homes, boarding homes, assisted living facilities, state veterans homes, and adult family homes. It applies to the entire admissions packet and its attachments, such as the statement of residents’ rights and facility rules. These must be consistent with the residents’ rights and licensing laws. RCW 70.129.150(2). In short, state law overrides illegal contract provisions.

There is a reason for this. Long-term care residents are generally very elderly and/or disabled. They are vulnerable and depend on the care facility far more than the typical tenant depends on a landlord. Some may have no one else looking out for them. Thus, the law requires care facilities to promote and protect their residents’ rights and interests. For countless facilities that also is their priority and intention. Appropriate admission agreements can help facilities in this responsibility—educating residents and guiding facility practices.

Disclaimer: The following analysis is intended to be a guide. It addresses key points of the residents’ rights law, but is not a comprehensive statement of the law nor offered as legal advice or consultation. Moreover, laws change. Before you use or revise an admission agreement, it is recommended that you consult with an attorney experienced in the area of long-term care law who can provide you with current, individualized advice.

II. Applicable Laws

RCW 70.129 sets forth residents' rights applicable in adult family homes, boarding homes, and state veterans homes. Additional details, such as on resident care planning or staff training, are found in the state regulations: WAC 388-76 for adult family homes (AFHs); WAC 388-78A for boarding homes (BHs); and WAC 388-110 for boarding homes with DSHS clients under the state's adult residential care, enhanced adult residential care, or assisted living services programs.

Most of RCW 70.129 -- except for RCW 70.129.105 and .150 -- does *not* apply to nursing homes. But similar, and in some areas more extensive, rights for nursing home residents are found in state and federal law at RCW 74.42, WAC 388-97, and 42 CFR § 483.¹ Please note: the state nursing home regulations (WAC 388-97) were substantially re-organized and amended, effective March 26, 2000. Be sure to have the current version.

Many other laws apply to long-term care facilities, too many to list. Of particular importance, however, is the abuse and neglect laws, RCW 74.34, which was amended effective July 27, 1999. Noteworthy changes include much clearer definitions of abuse and neglect, strengthening of the whistleblower protections, and clarifying that all staff in care facilities (along with agency staff and others) have a duty to report suspected abuse, neglect, exploitation, and abandonment. *A brief summary of the amendments to the abuse and neglect law, RCW 74.34, is available from this author upon request.*

III. General Provisions Governing Admission Agreements

A. Disclosures by the Facility²

1. Disclosures of services, items, and activities

Some care problems arise because of a mis-match between the facility and the resident. Starting in 1998, the state legislature required more 2-way disclosure by facilities and potential residents *before* admission: disclosure by the facility of the care it can provide, and by the potential resident of the care he or she needs.

¹ "RCW" stands for "Revised Codes of Washington," the laws or statutes passed by the Washington State Legislature. "WAC" refers to "Washington Administrative Code," the regulations adopted by a state agency, such as the Department of Social & Health Services (DSHS). "CFR" refers to the "Code of Federal Regulations," adopted by a federal agency. Statutes, passed by Congress or the state legislature, have greater authority than regulations. Regulations are often more detailed. They do have the status of "law." Courts interpret statutes, regulations, and the Constitutions and, for better or worse, may fill in the gaps.

² Note: Not all disclosure requirements and residents' rights are listed in this memo. For example, residents have the right to voice grievances, examine the state licensing inspection, and form resident councils. Typically these rights would be listed in a residents' rights statement, attached to the admission agreement. For the sake of brevity they are not all discussed here. The model admission agreement contains a more complete list of rights.

Long-term care facilities are required to clearly specify prior to admission:

1. the services, items, and activities typically available in the facility, or that can be arranged or permitted,
2. the charges for those services, items, and activities, including charges not covered by the facility's basic rate, or by Medicaid or Medicare, and
3. what services cannot be provided at the facility

RCW 70.129.030(4) and .110(2); WAC 388-97-07005 ³

The disclosure must be in writing in a language that the resident or his or her representative understands. RCW 70.129.030(4). *Example:* A spoken language that is understood, i.e., Spanish, Korean, Russian; large type for visually impaired; and comprehensible language, not full of legalese.

The disclosure should be in sufficient detail to give a clear and complete notice. See RCW 70.129.030(4) and .110(2). *Example:* Stating the facility will charge an "additional" amount for oxygen service is not a sufficiently clear, prior statement of the charges.

Adult family homes are required by WAC 388-76-60050(2) to disclose additional information to prospective residents, such as:

1. the caregivers' experience and training,
2. the extent to which a nurse is involved in resident care,
3. whether nurse delegation is performed at the home, and
4. the types of increased care that can or cannot be provided as residents' needs increase

2. Notice of rights, responsibilities and facility rules

Facilities are required to inform residents orally, and in writing in a language the resident understands, about:

1. the resident's rights and responsibilities in the facility,
2. the facility's rules and policies governing resident conduct, and
3. the regulations governing the resident's stay

This information may be given prior to or upon admission and must be acknowledged in writing. RCW 70.129.030(1) and (5); WAC 388-76-60050(1); WAC 388-97-07005. In non-nursing homes, the facility rules must be disclosed prior to admission. RCW 70.129.030(4). In practical terms, it is best to create one "admissions packet" that contains all the information and is given to prospective residents.

³ To avoid duplicate citations to state and federal law, the nursing home citations will list the state law.

Often, admission agreements deal principally with a few key provisions and then attach a number of documents listing the available services, the house rules, and the residents' rights. This arrangement is fine, but the applicable disclosure laws govern the entire packet.

Facilities can and should have rules governing resident conduct, but the rules must be reasonable and designed to protect the rights and quality of life of the residents. RCW 70.129.140(2). The facility rules cannot supercede or conflict with residents' rights. RCW 70.129.105 and .150(2); WAC 388-97-051(4); WAC 388-76-60070(1).

- *Example:* Residents cannot be discharged for "violating house rules." A house rule that residents must take their medications or be discharged, is overbroad. It violates the resident's right to remain in the facility unless they actually endanger the health or safety of residents. Failing to take medications might lead to this danger, but the danger may be avoided or minimized through other care interventions.

3. Deposits, Fees and Refunds

For private pay residents, RCW 70.129.150 and WAC 388-97-07005(6) set forth the law governing admissions fees, deposits, prepaid charges, minimum stay fees, and refunds of any deposits or charges. Medicaid and Medicare residents have additional protections. Facilities are required to fully disclose their deposit, fee and refund policies to prospective residents. RCW 70.128.150(1).

The law governing private pay residents is convoluted and has spawned numerous questions. *A detailed memo explaining the deposit and refund laws is available from this author upon request. A shorter memo explaining the law is available from DSHS, as AASA Dear Provider Letter #98-024.* Section IV.A. of the current memo explains the essential aspects of the deposit and refund laws.

B. Disclosures by the Resident

Prior to admission, except in cases of genuine emergency, facilities are required to obtain a thorough assessment of the resident's care needs and preferences. RCW 70.129.030(3). Nursing homes are permitted to admit residents with less initial assessment information, and then must complete a comprehensive assessment within 14 days. WAC 388-97-085. The assessment information should be obtained from the prospective resident, if possible, the resident's family, the resident's physician, case manager, if any, and others.

The assessment must contain the following minimum information, unless it is unavailable:

1. recent medical history,
2. current and contraindicated medications,
3. medical diagnosis,

4. significant known behaviors that may cause concern or require special care,
5. mental illness, if any,
6. level of personal care needs,
7. preferences for activities and services, and
8. other preferences, such as food and daily routine

Adult family homes are required to obtain additional information about the prospective resident, such as an evaluation of the resident's cognitive status, the resident's history of depression and anxiety, if any, and a preliminary service plan for the resident. WAC 388-76-61020.

The 2-way disclosure laws have been helpful in better matching facilities and residents. However, human nature being what it is, there's a natural tendency for some facilities to exaggerate their capabilities and some residents (or their families) to understate the residents' needs. The question arises: can a resident be discharged for "misrepresenting" his or her needs on the application? No. The discharge laws state that a resident has the right to remain in the facility except for certain reasons, which do not include misrepresentations on an admission application. However, a resident can be discharged if it is necessary for the resident's well-being and the resident's care needs cannot be met at the facility, even with reasonable accommodations to the resident's needs. RCW 70.129.030(3); RCW 70.129.110(1) and (3); WAC 388-97-042(1) and (3).

The corresponding question arises: Can the resident simply terminate the contract if the facility exaggerated its capabilities and services? No. However, if the resident needs to transfer to another facility for more appropriate care, he or she can transfer with less than the usual 30 days notice, and the facility is limited in how much it can charge the departing resident under those circumstances. RCW 70.129.150. (Details of this law are in section IV.A. below.)

C. Residents and Surrogate Decisionmakers

Who may exercise the resident's rights, including the signing of admission agreements?

1. The resident if competent,
2. If the resident has been found incompetent by a court in a guardianship, then the guardian, and
3. If the resident appears incompetent, but there has been no guardianship proceeding, then state law sets forth the list of authorized representatives. In order of authority they are the holder of a durable power of attorney, spouse, adult children, parents, and siblings. RCW 7.70.065.

The rules and restrictions governing health care decisionmaking on behalf of an incompetent person are complex. *A detailed memo explaining health care decisionmaking laws is available from the author of this memo upon request.*

Facilities cannot require prospective or current residents to appoint a durable power of attorney, nor can a facility discriminate against or refuse to admit a resident who does not have an advance directive. 42 USC § 1396a(w)(1); WAC 388-97-065(3); WAC 388-76-690(6). However, if the facility believes the resident is clearly incompetent, the resident should not be signing the admission documents. An appropriate, close family member, following the provisions of RCW 7.70.065, can sign the necessary paperwork.

D. Waivers of Liability

The residents' rights law expressly forbids all long-term care facilities from requiring or requesting residents to sign waivers of even potential facility liability for losses of personal property or injuries. RCW 70.129.105; WAC 388-97-655(3); WAC 388-97-051(4). Any language limiting the facility's potential liability, directly or by implication, is void.

- *Example:* "Resident voluntarily agrees that the facility is not responsible for the loss of any money, valuables, or personal property" is an illegal provision.
- *Example:* "Facility is not responsible for the consequences of resident leaving against medical advice." The resident has a right to choose discharge and cannot be held against his or her will. The facility would need to take reasonable measures to protect the resident, such as arranging home health care, in order to make the move as safe and orderly as possible. The above provision is an improper attempt to limit liability.
- *Example:* "The resident voluntarily refuses a recommended restraint. The facility is not liable for injuries that may result from this refusal." The resident has the right to refuse treatments. The facility would need to take other precautions to the extent possible.

The facility is obligated to provide residents with a safe environment, protect residents from reasonably foreseeable risks, and to protect and promote the rights of residents. *See e.g.*, RCW 70.129.020 and WAC 388-97-051. The facility is held to a negligence standard, but the extent of the protection required depends on the vulnerability of the residents. For *example*, when a resident is in a single room and has a history of screaming that is ignored by staff, the risk of an attack by an outsider going unnoticed is considered "foreseeable" and the facility can be liable for the injuries. Shepard v. Mielke, 75 Wn.App. 201 (1994).

The facility is responsible for loss or damage to a resident's property *if* due to the facility's negligence. *See e.g.*, WAC 388-97-051(5). The facility cannot increase this standard to require liability only if the facility is grossly negligent or reckless. What constitutes negligence by the facility is not set forth in the law. It would turn on the extent of the resident's inability to protect his or her belongings and the availability of reasonable precautions that the facility could take. In about 1994, nursing homes received from DSHS a 3 page list of practical steps they could take to lessen or prevent losses and thefts of residents' property. These include such simple measures as using clear plastic liners for wastebaskets. Nursing homes are now expressly required to "have

a system in place to safeguard personal property within the nursing home that protects the personal property and yet allows the resident to use his or her property.” WAC 388-97-07060. The resident cannot be required to keep personal property locked in the facility office or safe. *Id.* A copy of the list of practical suggestions to prevent losses is available from DSHS or this author upon request.

Sometimes a waiver of potential liability is subtle—perhaps unintentional—but nonetheless violates state law.

- *Bad example:* “The facility does not insure against losses. The facility recommends that the resident obtain personal property insurance.” This implies that the facility is not responsible for losses, and will not pay for them, so the resident should obtain insurance if the resident wants protection. Yet, while the facility might not have insurance to cover the loss, it could still be liable to pay for the loss. The resident is not told this. This is an example of how telling half the truth can be deceiving.

Good examples of contract provisions concerning property losses do exist. One model worked out by a group of attorneys and providers reads as follows:

- *Good example:* “The Resident and the Facility shall both take reasonable steps to ensure that the Resident’s property is not lost, stolen, or damaged. If the Resident’s unit is lockable, the Resident shall be issued a key to the unit. If the Resident’s unit not lockable, the Resident will be provided with lockable storage space upon request. The Facility will be responsible for loss or damage to the Resident’s property to the extent such loss or damage is caused by the Facility’s negligence. However, because not all loss or damage will be caused by Facility’s negligence, and because the Facility’s insurance may not cover losses for which the Facility is *not* responsible, the Resident is encouraged to maintain insurance to cover loss or damage to Resident’s personal property.”

E. Waivers or Limits on Residents’ Rights

While there is no law prohibiting a citizen from waiving or modifying a legal right, there *is* a law prohibiting residents in long term care facilities from waiving his or her resident rights. For *example*, while you can agree to use a dispute resolution procedure instead of initiating a lawsuit, a LTC resident cannot sign a document agreeing to do so. RCW 70.129.105 provides that no long-term care facility can require or request a resident to waive any residents’ rights, which would include the right to sue for injuries or losses.

Sometimes the waiver or limitation on rights is subtle or indirect:

- *Example:* “The rights of the tenant are limited to those rights herein expressly granted.” Or, “This contract sets forth the entire terms governing the tenancy.” These provisions are invalid because the contract cannot limit the resident’s rights. The contract undoubtedly does not set forth all the residents’ rights laws that apply to a

care facility, such as the Americans with Disabilities Act (ADA), and those found in the licensing laws and RCW 70.129.

- A provider also cannot go along with another person's attempt to limit a resident's rights. *Example:* a family member may want to restrict DSHS access to a resident or to the resident's care records, or may demand that the resident be restrained inappropriately. The provider must uphold the resident's right to access and oversight by DSHS, and the resident's right to be free from restraints. RCW 70.129.090(1); RCW 70.12.120; WAC 388-97-055(8)(c).

IV. Financial Provisions

A. Deposits, Fees and Refunds

1. Private pay residents

Prior to admission, all facilities must fully disclose in writing, in a language understood by the resident or the resident's representative:

1. The amount of any admission fees, deposits, prepaid charges (such as the last month's rent), and minimum stay fees,
2. The facility's transfer/discharge and advance notice requirements,
3. The policy concerning refund of deposits, fees, and charges, and
4. A notice that the facility will refund the damage deposit, if any, less charges for damage caused by the resident beyond normal wear and tear, within 30 days of the resident's death, discharge or transfer.

RCW 70.129.150(1) and WAC 388-97-07005(6).

To minimize future disputes, the facility should (though is not required to) provide the resident with:

5. A written description of the condition of the resident's room/unit upon admission, and
6. An explanation of any charges or deposit kept by the facility after the resident leaves

If a private pay resident dies, is hospitalized, or is transferred to another facility for more appropriate care, and does not return to the original facility, then the facility must comply with the following refund requirements:

1. Regardless of whether or not the resident has given the advance notice otherwise required in the admission agreement, such as 30 days prior notice, the facility must refund any deposit or charges already paid, minus the facility's per diem rate for the days the resident actually resided or reserved or retained a bed in the facility; however,

2. The facility may retain an additional amount to cover its reasonable, actual expenses incurred as a result of the resident's move, not to exceed five days' per diem charges. The facility may not keep this additional amount if the resident has given the advance notice required in the admission agreement.

RCW 70.129.150(1) and WAC 388-97-07005(6).

In an effort to reduce the number of days that a resident is considered to have "retained" a bed in the facility, the provider should adopt a policy—and inform the residents—that it will make reasonable efforts to store personal items that are left at the facility following a transfer. Such storage costs will undoubtedly be lower than a facility's per diem charges, thus both lessening the cost to residents and their families, and benefiting the facility's community relations.

Numerous questions have arisen because of the convoluted language of the above law. Brief answers are as follows:

- The 5 days' limit on charges for move out related costs only apply when the resident dies, is hospitalized, or transfers to "another facility for more appropriate care." Facilities can adopt other, reasonable refund policies for other transfers.
- The term "more appropriate care" is not defined in statute, but would generally mean when the transfer is done to enhance the resident's quality of care or quality of life. This could include transfers to facilities with more appropriate activities or where the resident's native language is spoken.
- The statute does not say who determines "more appropriate care." If not negotiated between the resident and facility, it may go to the ombudsman, DSHS, or court.
- Admission fees can be charged, if clearly disclosed in writing. The statute does not forbid non-refundable admission fees. However, if they were so large as to operate as a minimum stay fee, they would be governed by the 5 days' limit on retained charges.
- The term "per diem" in "5 days' per diem charges" is not defined in statute. Courts would likely give "per diem" its common meaning, such as: "the daily charge found by dividing the monthly charge by the number of days in the month." Inflated per diem charges would be considered unconscionable and contrary to the intent of the law.
- Facilities can charge for "reasonable, actual expenses incurred as a result of a private-pay resident's move"—such as room cleaning and advertising—but not for lost income or revenue.
- Non-refundable discharge or move-out fees are governed by the 5 days' limit on charging for reasonable, actual expenses incurred for a move.
- If a damage deposit was required, residents can be charged for damages that *exceed* normal and reasonably foreseeable wear and tear. What is normal wear and tear will vary with the kinds of residents served by the facility. *Example:* Incontinent residents will foreseeably stain a carpet or bed, and residents with dementia may foreseeably put objects into toilets.

2. Medicaid and Medicare nursing home residents

RCW 70.129.150 applies to all residents, but Medicaid and Medicare eligible *nursing home* residents also have rights under federal law. These residents (or prospective residents) cannot be charged a deposit or required to stay a minimum number of days in the nursing home. 42 CFR §§ 483.12(d)(3); 489.22; 489.53(a)(2). The nursing home may not charge, solicit or *accept*, in addition to the Medicaid or Medicare payment, any gift, money, or donation as a precondition of admission, expedited admission, or continued stay at the facility for the Medicaid or Medicare eligible resident. 42 CFR § 483.12(d)(3). State law is now consistent with federal law. WAC 388-97-07005(4). In short, the nursing home cannot charge them a deposit and the facility is paid only for the days the resident is a resident of the nursing home.

B. Third Party Guarantors in Nursing Homes

In Medicaid and Medicare certified nursing homes (which are nearly all nursing homes), it is illegal to require *or request* a third party guarantee of payment as a condition of admission, expedited admission or continued stay at the facility. 42 CFR 483.12(d)(2); WAC 388-97-017(2)(c). In other words, it is illegal to require someone other than the resident to sign the admission agreement as a guarantor of payment or a "responsible party." Nursing homes may require an individual who has legal access to the resident's money to sign the admission agreement and, without incurring personal liability, to pay for the nursing home care from the resident's income or resources. *Id.*

Nursing homes are required to inform, in writing, the prospective resident, and where applicable, the resident's representative, before or at the time of admission, that a third party may not be required or requested to personally guarantee payment to the nursing home. WAC 388-97-017(3).

The rule on third party guarantors applies to *all* residents and prospective residents in Medicaid or Medicare certified nursing homes, both state pay and private pay residents. 56 Fed. Reg. 48841 (Sept. 26, 1991); WAC 388-97-017(1).

Similar rules and restrictions do not apply in boarding homes or adult family homes.

C. Fee Increases

In general, long-term care facilities must give *30 days'* prior written notice before "changes in the availability or the charges for services, items, or activities, or of changes in the facility's rules." RCW 70.129.030(4); WAC 388-97-07005(5). In other words, a 30 days' notice is required for a fee increase.

There are two exceptions to the 30 days' notice requirement:

1. In an emergency (which isn't defined), 30 days' notice is not required, and

2. For adult family homes, if there is a substantial and continuing change in the resident's condition necessitating substantially greater services, then 14 days' notice is sufficient.

RCW 70.129.030(4).

One important issue is not entirely clear in the law, namely: what is meant by a change in the "charges for services"? Providers often offer levels of care, charging for example \$2,000 a month for level A, \$3,000 a month for level B, and \$4,000 a month for the most complex care, level C. Some of these providers maintain that if they assess a resident in mid-month as needing to switch to a higher level of care, they can impose an *immediate* increase in charges to the resident. They argue that they are not changing the charges for the services, they are switching the resident to a new level of care and charging the resident for that level of care services. The charges to the resident are changed, but not the charges for the services. Under this interpretation, "services" are defined narrowly as "level A services" or "level B services," rather than as "boarding home services" or "adult family home services."

The alternative interpretation is that these providers have construed a part of the statute outside the context of the remainder of the statute. The rest of RCW 70.129.030(4) contemplates the exact circumstance of a resident needing to switch to a higher level of care and does not permit an immediate increase in charges. The statute says that "if there has been a substantial and continuing change in the resident's condition necessitating substantially greater or lesser services, items, or activities, then the charges for those services, items, or activities may be changed upon 14 days' advance written notice." Under this interpretation, the facility must provide the greater services needed by the resident (or potentially be guilty of neglect), but after 14 days the facility can increase the charges for those services. In other words, it can then increase the charges to the resident for the services he or she is receiving.⁴

The shortened notice period of 14 days is only available to adult family homes. RCW 70.129.030(4). As smaller facilities, they do not have a high number of residents to spread out a spike in costs for one resident. Boarding homes and nursing homes, by contrast, can spread costs out over many residents, some of whom will be improving as others are declining.

The danger in the first interpretation above (that residents can be switched to a higher level of care and immediately charged that higher rate) is that residents' may be faced with a sudden, substantial fee increase, completely at the discretion of the provider. This leaves residents faced with either paying the higher, unplanned fees or undergoing the trauma of moving.

⁴ This approach is similar to one used by DSHS in adult family homes for department clients whose needs have significantly changed: the payment rate cannot be changed until approved by the department. WAC 388-76-61570.

The danger in the second interpretation (higher level of care charges can only be imposed after 14 or 30 days' notice) is that some providers may neglect their resident(s) if they are not paid right away for their increased costs. This problem could be reduced by the emergency clause in RCW 70.129.030(4) (allowing less than 30 days' notice). Providers also could anticipate some increased needs and costs and build these into their base charges. Nonetheless, some providers will feel "cheated" by this second interpretation, and may be tempted to cut corners or simply will be unable to absorb, even temporarily, the extra costs of caring for a higher need resident. Ultimately, this question of statutory interpretation may need to be resolved by the courts.

D. Medicaid Supplementation and Discrimination

1. Supplementation

The admission agreement for boarding homes and adult family homes should clearly say whether it is for a Medicaid or private pay resident. Items charged to private pay residents might constitute illegal supplementation if charged to Medicaid residents. *Example:* Charges for laundry, shopping, travel to medical appointments, if within the care plan, are covered by Medicaid. *See e.g.,* WAC 388-110-150.

Nursing home residents cannot be charged for items and services covered by Medicaid or Medicare. 42 CFR §483.10(c)(8); WAC 388-97-07015(7). Intentionally charging *or accepting* additional payment for covered items or services is a felony. 42 USC §1320a-7b(d); RCW 74.09.260. Nursing homes can charge for items and services not covered by Medicaid, provided that the resident was properly notified of the costs and requested and received the extra items or services. 42 CFR §483.12(d)(3)(1); WAC 388-97-07015(8).

Medicaid residents in adult family homes or boarding homes also cannot be charged for services covered by Medicaid, such as the services set forth in the negotiated care plan or negotiated services agreement between the resident and the facility. *See e.g.,* WAC 388-87-007 and 388-87-010(6). Providers can receive additional payment from the resident for services not covered by Medicaid, such as cable TV or a private in-room telephone line, if are voluntarily agreed to by the resident or the resident's representative.

It is sometimes difficult to determine what is covered by Medicaid and what can be purchased separately by the resident or the residents' family. *A recent memo on Medicaid Supplementation can be obtained from Columbia Legal Services. Ask for the Senior Bulletin: Medicaid—Institutional/COPES, Vol. 00-3 (March 27, 2000) by Joy Ann von Wahlde.*

2. Discrimination

RCW 74.42.055 prohibits Medicaid certified *nursing homes* from discriminating against Medicaid residents. Nursing facilities must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services covered under the

Medicaid state plan for all residents regardless of the resident's source of payment. WAC 388-97-017(1). Prohibited discrimination includes:

1. denying or delaying admission because of the resident's Medicaid status,
2. keeping one waiting list for the portion of the facility certified Medicare and Medicaid (often erroneously called the Medicare beds)⁵ and another waiting list for the Medicaid beds,
3. transferring a resident from one room to another room in the facility because of the resident's status as a Medicaid recipient,
4. charging Medicaid residents a rate in excess of the Medicaid rate, except for permitted supplementation, and
5. discharging a resident because of the Medicaid status.

RCW 74.42.055; WAC 388-97-017(4) and (5).

Medicaid certified nursing homes must maintain *one waiting list* of people seeking admission to the entire facility, kept for one year, in order by date of the request for admission. RCW 74.42.055(3); WAC 388-97-017(5). Permissible grounds for not admitting an applicant, i.e., skipping to a different person on the waiting list are: (a) if the nursing home cannot meet the needs of the applicant with available staff or through the provision of required reasonable accommodations, or (b) if the admission of the applicant would prevent the needs of the other residents from being met. RCW 74.42.450(1); RCW 74.42.055(6); WAC 388-97-017(5).

Violation of the state's Medicaid discrimination law is a Consumer Protection Act violation, which provides a prevailing plaintiff compensation for actual damages, reasonable attorneys fees and costs, and potential treble damages up to \$10,000. RCW 74.42.055(5); RCW 19.86.090.

The above Medicaid discrimination laws do not apply to boarding homes or adult family homes. If a boarding home or adult family home has a contract to serve DSHS clients under a Medicaid related program, additional rules governing the facilities' practices vis-à-vis Medicaid residents are found in the contracts with DSHS and, for the boarding homes, in WAC 388-78A.

V. Selected Additional Residents' Rights

A. Resident Self-Determination and Quality of Life Issues

Residents have the right of self-determination and the right to participate in the development of their care plan to the maximum extent possible. *See e.g.*, RCW 70.129.020 and .140; WAC 388-97-052, -08030 and -090(4); WAC 388-76-61530.

⁵ In Medicaid certified nursing homes, *all* beds are Medicaid certified. Thus, in a nursing home certified under both Medicaid and Medicare, the beds certified for Medicare are also certified for Medicaid. WAC 388-97-07070.

Example: This may include, but is not limited to, meals, bed times, visiting hours, refusing medical treatment or taking medication, and refusing baths.

The resident also has the right to make choices about aspects of his or her life in the facility that are significant to the resident. RCW 70.129.140; WAC 388-97-08030. This right can cover many items. As a rule of thumb: if it's significant to the resident, then it's significant to the resident.

Residents have the right to choose activities consistent with their interests and needs. RCW 70.129.140(2); WAC 388-97-08050. Prospective residents must be told prior to admission of the activities customarily available in the facility, or could be arranged. RCW 70.129.030(4). If the activities do not meet the needs and interests of residents, the facility must reasonably attempt to provide, or arrange for, activities that meet these preferences. This would be a "reasonable accommodation of individual needs and preferences" required under RCW 70.129.140(5)(a) and WAC 388-97-08010(2), and would satisfy the facility's obligation to provide care in a manner that recognizes each resident's individuality. RCW 70.129.140(1).

- *Example:* The provision of "regularly planned activity programs" may not meet the individual needs and preferences of residents. Within the bounds of reasonable facility rules, the activities need to be designed to meet residents' preferences.
- *Example:* A reasonable accommodation may be to permit the resident to have a pet, which are often comforting. They may fulfill a resident's need or preference. Access to pets is an express right for nursing home residents. WAC 388-97-08070. Facilities should have reasonable health and safety restrictions regarding pets (such as no large dogs, all shots required) and may impose a reasonable pet fee---the fee being unreasonable if it effectively bars pets.

Residents and families have the right to form resident councils and family councils. Staff, ombudsmen or others, can attend the meetings at the *invitation* of the group. The facility must respond to the groups' grievances and recommendations. RCW 70.129.140(3); WAC 388-97-08040.

Residents have the right to interact with people both inside and outside the facility. RCW 70.129.140(2)(b) and WAC 388-97-051.

A guardian or other decisionmaker cannot keep a resident in a facility against his or her will. RCW 11.92.190; 11.94.010(3). Clearly, it may be difficult to know the "will" of a cognitively impaired resident, but the desire to leave the facility may, at a minimum, indicate unhappiness with the activities, services, or other aspects of the facility. The two basic rules govern decisionmaking by a guardian or other surrogate decisionmakers for an incompetent person are to:

1. Choose what the particular person with his or her individualized preferences, would want done if he or she were competent to decide; and

2. If, and only if, this cannot be determined, make a decision that you believe is in the person's "best interests."

RCW 7.70.065(3); In re Ingram, 102 Wn.2d 827, 840-42 (1984). In any case, the resident has the right to participate in these decisions to the maximum extent possible. WAC 388-97-052, -08030 and -090(4); WAC 388-76-61530. These rights cannot be waived or limited by an admission agreement. In fact, they should be protected and promoted by the facility.

B. Visits and Access by Others

Residents have clear rights to access, and to be accessed by many individuals and agencies. RCW 70.129.090 and WAC 388-97-07050.

1. Visiting/telephone use hours: Only *reasonable restrictions necessary to protect the rights of other residents* can be imposed upon immediate family members, relatives and others visiting the resident, RCW 70.129.090 and .140(2).
2. A provider can recommend times for visiting, but the admission agreement must make clear that this is just a recommendation, and that the resident can be called and/or visited at any reasonable time.
3. There can be no restrictions placed upon access by the resident's doctor, state representatives, the ombudsman program, or the protection and advocacy (P&A) program.
4. A resident has the right to refuse to see family members and others.

Neither the facility, nor family members, guardians, nor others can prohibit the resident's doctor, the ombudsman, the P&A, or state representatives from having access to any resident. WAC 388-97-07050(3); WAC 388-76-595; WAC 365-18-100 (new ombudsman regulations).

C. Privacy and Records

Residents have a right to personal privacy, including privacy in:

- Accommodations,
- Medical treatment,
- Written and telephone communications,
- Personal care,
- Visits, and
- Meetings with family and resident groups.

RCW 70.129.050 and .080; WAC 388-97-07020.

Residents may approve or refuse the release of personal and clinical records to individuals outside the facility, unless the resident is incompetent, or disclosure is required by law. *Id.* However, residents cannot be required to share information about

themselves to the facility that is not related to care and services. *Example:* The resident cannot be required to disclose value of personal property held in facility.

The resident and his or her representative has access to "all records pertaining to himself or herself" within 24 hours and a copy of the records, "at a cost not to exceed the community standard," within 2 working days advance notice. RCW 70.129.030; WAC 388-97-07005(2). The nursing home regulations say that photocopying costs cannot exceed 25 cents per page. *Id.* The federal agency that oversees nursing homes defines the term "records" to include clinical records and "all records pertaining to the resident, such as trust fund ledgers pertinent to the resident and contracts between the resident and the facility." HCFA, Interpretive Guidelines at PP-5, F-153 (June 1995).

D. Personal Property Use

Residents have 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." RCW 70.129.100; WAC 388-97-07060. The care facility—or more concretely, the resident's room or part of a room—is now the resident's home. Thus, a resident can and should wear his or her own clothing and, to the extent possible, use his or her own furniture. These belongings often carry significant symbolic and emotional value.

The facility cannot limit the value of personal property brought into the facility, since that is a personal choice of the resident's. The facility cannot require residents to keep possessions or valuables locked up, since residents have the right to "retain *and* use" their possessions. *Id.*

As noted earlier, the facility should have in place a system to safeguard the residents' property, and the facility cannot limit its potential liability for losses in an admission agreement or other document. *Id.*

VI. Transfer and Discharge Provisions

A. Transfers *from* the Facility

1. Permissible grounds for transfer/discharge

All long-term care facility must permit residents to remain in the facility, and not transfer or discharge the resident against the resident's will unless:

1. The resident has failed to make the required payment for his or her stay;
2. Transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met by the facility;

3. The safety of individuals in the facility is endangered;
4. The health of individuals in the facility would otherwise be endangered; or
5. The facility ceases to operate.

RCW 70.129.110; WAC 388-97-042.

If the facility transfers or discharges the resident for one or more of the above reasons, the facility must provide written notice of the discharge to the resident and his or her representative at least 30 days in advance. However, written notice may be made on less than 30 days, and as soon as practicable before discharge or transfer if: (1) the health or safety of individuals in the facility would be endangered, (2) an immediate transfer or discharge is required by the resident's urgent medical needs, or (3) the resident has not resided at the facility for 30 days. *Id.*

Before transferring or discharging a resident, unless the resident agrees to the move, the facility must attempt through reasonable accommodation, to avoid the transfer or discharge. RCW 70.129.110(3); WAC 388-97-042(3). "Reasonable accommodation" has the meaning given to this term under the federal Americans with Disabilities Act (ADA) of 1990, 42 U.S.C. § 12101 et seq. and other applicable federal or state anti-discrimination laws and regulations. RCW 70.129.010(8); WAC 388-97-005. These are explained more fully below.

The facility must also provide sufficient preparation and orientation to the resident to ensure safe and orderly transfer or discharge from the facility. RCW 70.129.110(6); WAC 388-97-042-(3). Detailed discharge planning requirements applicable to nursing homes are set forth at WAC 388-97-032. Boarding home and adult family home operators should-examine that regulation, as it contains many excellent discharge planning suggestions that would minimize the dangers of "transfer trauma."

Remember, if the resident dies or is transferred to a hospital or another facility for more appropriate care, and does not return to the original facility, the facility must comply with the refund requirements set forth in Section VI.A above.

2. The ADA and reasonable accommodations

(a) Statutes and regulations

Under the Americans with Disabilities Act (ADA), long-term care facilities may not discriminate in the admission, transfer or discharge of a prospective or current resident based on his or her disability, if the disability can be reasonably accommodated. 42 USC §12182(a). Prohibited discrimination includes:

1. The imposition of eligibility criteria that tend to screen out an individual with a disability unless the criteria is necessary for the provision of the goods or services.
2. A failure to make "reasonable modifications in policies, practices, or procedures," unless the modifications would fundamentally alter the nature of the goods, services, or facilities, and
3. A failure to provide auxiliary aids and services, unless taking such steps would fundamentally alter the nature of the goods, services or facility, or would result in an "undue burden."

42 USC §12182(b)(2)(A).

In other words, changes must be made in a facility's policies, practices and services, which would include staffing levels and patterns, unless the changes would preclude caring for the other residents, fundamentally alter the nature of the facility, or cause an undue burden.

An "undue burden" is one that causes a significant financial expense or administrative burden. The financial situation of the facility and its parent corporation, among other things, is taken into consideration in determining the extent of the burden. 28 CFR §36.104, 36.303. In other words, more accommodations would be expected from a nursing home or assisted living facility that is part of a large chain than would be expected from a single adult family home.

If the resident poses a "direct threat" to the health or safety of others, there is an exception to the reasonable accommodations requirement. The direct threat must be one that creates "a significant risk that cannot be eliminated by a modification of policies, practices, or procedures or by the provision of auxiliary aids or services." 42 USC §12182(b)(3); *see also* 28 CFR §36.208(c). Courts have construed the standard of "eliminating" the risk to be met by "acceptably minimizing the risk." Roe v. Sugar River Mills Associates, 820 F.Supp. 636, 640 (D.N.H. 1993).

The ADA standard applies to all long-term care facilities, *see* RCW 70.129.010(8), and has been expressly set forth in the state nursing home regulations. *See* the WAC 388-97-005 definition for "reasonable accommodations." This standard applies to both resident admissions and discharges. RCW 70.129.030(3) and 70.129.110(3); WAC 388-97-017(5) and 388-97-042(3); RCW 74.42.450. This standard should guide facilities in their determination as to whether a resident's needs can or cannot be met in the facility, and whether the resident's behavior actually endangers the health or safety of other individuals, or could be modified through reasonable accommodations.

(b) Case law

In practice, courts have scrutinized these cases closely. In two Washington State administrative fair hearings, the judges refused to authorize the discharge of two nursing home residents with dementia who had threatening behavior. One resident was a "wanderer" and the second resident had been sexually touching other residents without their

consent. In re E.R., Washington State Office of Administrative Hearings, Docket No. 1293 A-211 (March 16, 1994); In re A.B., Washington State Office of Administrative Hearings, ⁶Docket No. 0394 A-415 (July 22, 1994). The discharges were denied on the basis of federal nursing home law—principally the resident assessment and care planning requirements—and, for the first time, also on the basis of the federal anti-discrimination laws. The key holding in the decisions was captured in the final paragraph of In re E.R.:

“As a skilled nursing facility, [P.W.] is required to develop and consistently apply an appropriate care plan. [P.W.] is required to make reasonable staffing accommodations for Appellant [the resident]. If [P.W.] is doing what it is required to do, then Appellant's sexually assaultive behavior will be eliminated. If [P.W.] is doing what it is required to do, then Appellant does not represent a danger to the safety of others at the facility. Another way of saying this is that the safety of the individuals in [P.W.] is not endangered by [E.R.], but is endangered by the failure of [P.W.] to have an appropriate care plan for [E.R.] which is consistently applied and by the failure to make reasonable staffing accommodations.”

In another decision with broad implications for long-term care facility residents, the federal appellate court in Wagner v. Fair Acres Geriatric Center, 49 F.3d 1002 (3rd. Cir. 1995) held that a nursing home violated the Rehabilitation Act, a federal anti-discrimination law similar to the ADA, when it refused to admit a prospective resident with Alzheimer's disease because of the "behavioral manifestations" of her disease.

Ms. Wagner was 65 year old woman with Alzheimer's whose family requested that she be admitted into the nursing home from a psychiatric hospital. Her symptoms included "screaming, agitation and aggressive behavior." The nearby nursing home, Fair Acres Geriatric Center, refused to admit Ms. Wagner. She was then admitted to a different nursing home, far away from her family.

Approximately 60% of the residents at Fair Acres' residents had dementia. [This is about the percentage in most nursing homes nationwide.] Staff at Fair Acres decided that because Ms. Wagner was not "symptom free"—which they defined as non-combative for two weeks—and therefore was unsuitable for admission. The doctors at the psychiatric hospital (who provided some consultation) said she had stabilized, that a standard of "symptom free" for two weeks was unrealistic, and that she was no different than other nursing home residents with dementia who have difficult, but predictable and relatively manageable behaviors. Staff at Ms. Wagner's current nursing home reported that her behavior was similar to other "difficult" Alzheimer's residents, but was generally manageable with low light, soft music, baths, and foot massages.

The *Wagner* court held that: (1) the Rehabilitation Act applied to nursing home admission decisions; (2) the decision to deny admission was an administrative decision, not

⁶ For example: "If the transfer is due to a significant change in the resident's condition, but not an emergency requiring immediate transfer, then prior to any action, the facility must conduct the appropriate assessment to determine if a new care plan would allow the facility to meet the resident's needs." HCFA, Interpretive Guidelines at PP-34, F201 (June 1995).

medical, based on resource allocation; and (3) the applicable discrimination standard was whether the facility could *not* make reasonable accommodations without either fundamentally altering the nature of its program or incurring an undue burden. The burden of proof was on the nursing home. The court found that Fair Acres cared for other residents with similar behavioral symptoms. Ms. Wagner's assaultive behavior occurred infrequently, was often predictable, and therefore could be accommodated.

The *Wagner* court did not need to address the issue under the ADA, which has similar (if not more protective) anti-discrimination standards.

In practice, often the basis for a transfer or discharge can be eliminated by close attention to medical problems, changes in the environment or alterations in the staff interventions. These may be considered "reasonable accommodations" or just good care practice.

Facilities should first eliminate possible medical causes for mental changes or behavioral problems that may be due to pain, anxiety, depression, or infections. Many "behavioral problems," especially from residents with dementia, are expressions of an unmet need. The surrounding environment may be triggering or contributing to the problem. For example, there may be inadequate security devices to stop wandering residents; the PA system may be loud and upsetting; a locked bathroom door can contribute to incontinence; frequent staff turnover and room changes can contribute to a resident's loneliness and sense of powerlessness; confrontative "reality orientation" interventions with a demented resident can trigger a catastrophic reaction. Sometimes the fix is quite simple: turning pants or shirts front to back for residents who are exposing themselves; serving the confused resident dinner in a small dining room rather than a large, noisy one; putting the combative resident in a room next to the nurses station rather than at the end of a hallway; or changing the bathing practices, such as using warm, calm baths for residents with dementia. All of these may be appropriate reasonable accommodations to the resident's disability and needs, allowing the facility to perhaps avoid a discharge.

3. Bed-holds and readmission rights

Medicaid residents in *nursing homes* who are temporarily hospitalized or go on social/therapeutic leave have specific rights to return to the first available semi-private bed if they still need nursing home care. WAC 388-97-042(4). The nursing home must inform residents and their family, in writing, of these rights during the initial admission and at the time of the hospitalization or leave. WAC 388-97-042(4). Too often this does not occur.

An important amendment to the nursing home regulations is the provision that Medicaid residents must be informed that "a Medicaid eligible resident may be charged if he or she requests that a specific bed be held, but may *not* be charged a bed-hold fee for the right to return to the first available bed in a semi-private room." WAC 388-97-042(4).

The right to be readmitted to a nursing home applies equally to medical and mental health hospitalizations or therapeutic leaves. HCFA at 56 Fed. Reg. 48840 (Sept. 26, 1991). In other words, if a resident had an acute episode of mental illness, and was detained under the involuntary commitment laws, once the mental health professionals (or court) said that the resident was ready to return to the nursing home, then the resident would have the right to be readmitted if he or she still needed nursing home care.

Nursing homes must adopt bed-hold policies, which must comply with these state and federal laws. WAC 388-97-042(1) and (4).

Bed-holds for DSHS clients in *boarding homes or adult family homes* are governed by the contract between the facility and DSHS and applicable state regulations. Generally, if the resident is absent from the facility for more than 15 consecutive days for social reasons, the facility must obtain approval from DSHS for payment. If the resident is hospitalized or temporarily placed in a nursing home, the facility will retain the resident's bed or unit for up to 30 days if the resident is likely to return to the facility. See WAC 388-110-100.

B. Transfers *within* the Facility

1. Room or roommate changes

Residents have the right to receive prior notice of room or roommate changes, and the right to share a room with their spouse, if both residents agree. RCW 70.129.140(5). In nursing homes, changes in rooms or roommates generally cannot occur without at least 3 days' prior notice, although the notice can be longer if necessary to protect the health or safety of a resident, i.e., to minimize transfer trauma, or shorter, such as to facilitate an admission to the facility. WAC 388-97-07065. Facilities must make reasonable efforts to accommodate residents' preferences, which would include roommate preferences. *Id.*

2. Medicare to Medicaid bed

Nursing home residents have the right to refuse a transfer within the facility when the purpose of the transfer is move the resident from a bed certified under Medicare and Medicaid (called "dually certified" beds) to a non-Medicare bed. 42 USC §1395i-3(c)(1)(A)(x); WAC 388-97-07070(1).⁷ The federal law was adopted in 1990 in order to address the problem of transfer trauma from frequent room transfers based not on care needs but reimbursement rates. Medicare usually reimburses facilities at a higher rate than Medicaid, and Medicare provides only a limited number of days of coverage. In order to maximize Medicare reimbursements, facilities have an incentive to transfer residents from a Medicare/Medicaid bed to a Medicaid bed once the resident's Medicare benefits end.

⁷ Residents have the corresponding right to not be transferred from a Medicaid only bed into a Medicare/Medicaid bed, although this is rarely the problem. WAC 388-97-07070(1).

A Medicaid resident who remains in the Medicare/Medicaid bed cannot be charged additional money. The facility must accept the Medicaid payment as payment in full for the resident's care. 42 USC §1320a-7b; WAC 388-97-07070(2). Nursing homes must inform residents of these rights at the time of a proposed transfer or relocation. WAC 388-97-07070(3).

In practice, most residents are moved out of their Medicare/Medicaid beds once their Medicare benefits end. According to reports to the ombudsman program, most of these residents are not informed that they can remain in their Medicare/Medicaid beds.

Private pay residents who choose to stay in the Medicare/Medicaid bed after exhausting their Medicare benefits can be charged the bed rate for that room—which is often very high—provided that they are notified in writing in advance as to what the charges would be for staying in that room. 42 USC §1396r(c)(4)(B)(i).

APPENDIX F



Here's Help

FROM THE LEGAL SERVICES DEVELOPER,
THE LONG-TERM CARE OMBUDSMAN AND COLORADO'S
PROTECTION AND ADVOCACY SYSTEM

CONTRACTING FOR BOARD AND CARE

PERSONAL CARE BOARDING HOMES

This paper is designed to assist you in examining contracts you may be asked to sign when making arrangements for living in a personal care boarding home.

DEFINITIONS

A personal care boarding home is a facility in which a resident is provided with room, meals, help with activities of daily living and some degree of protective oversight. Personal care boarding homes do not provide 24 hour medical or nursing care.

Personal care boarding homes are also called assisted living facilities, foster care homes, alternative care facilities and residential care facilities.

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Adult foster care homes provide personal care for low income adults and are regulated by the County Departments of Social Services.

Alternative care facilities are for persons certified as meeting the criteria for nursing home care and meeting income guidelines. They are certified by the State Department of Human Services.

Personal care boarding homes can be small private residences, a wing of a nursing home or attached to a senior high rise.

Colorado law requires that all personal care boarding homes with three or more persons be licensed by the State Department of Public Health and Environment.

WHAT TO LOOK FOR IN A CONTRACT

Once you have found a facility you think you would like to consider living in you will need to examine the contract. (For information on how to choose a facility see the "Consumer Guide and Resident's Rights for Personal Care Boarding Homes" available through the State Ombudsman Program at The Legal Center.)

Reviewing the contract is extremely important. If possible, have an attorney look it over for you. Illegal or misleading provisions in contracts may be unenforceable but unless the resident knows they are unenforceable the practical effect is to deter residents from exercising their rights.

When reviewing the contract look for the following provisions:

Does the admission contract include a clear, itemized list of services that are covered in the basic daily rate?

Does the admission contract include a clear, itemized list of charges for extra services that are available?

What charges are labeled as a deposit (and therefore refundable and subject to laws regarding escrow of the deposit) and what charges are considered entrance or admission fees (which may not be refundable)?

Does the contract provide for at least 30 days written notice of changes in services or changes in charges for services provided by the facility?

If the facility is an alternative care facility (accepting Medicaid payment), does the contract require the resident to pay as a private-pay resident for some period of time before converting to Medicaid?

Does the contract require a "responsible party", "cosigner", or "guarantor" to assume personal financial responsibility for the cost of the resident's care?

How much written notice must a resident give before moving out and how much written notice will the home give to a resident who is being asked to leave? (Some contracts require a certain number of days written notice even if the person dies or has a medical emergency requiring a transfer to a hospital or nursing home for more intensive care.)

What are the provisions for financial management if the care provider handles the resident's money?

Does the contract include a direct and complete statement of Residents' Rights? (You can get a copy of the Residents' Rights in

personal care boarding homes required under Colorado law from the State Ombudsman Program.)

Does the contract restrict residents to using only the services of a health care or personal care provider who is employed or under contract with the facility? (This could be a problem if you are restricted from using your Medicare provider and instead have to pay privately for services that are covered by Medicare.)

Who determines when care needs change and what changes are necessary?

Does the contract require the resident to accept the health care and personal services deemed appropriate for the resident in order to stay in the facility?

Does the contract incorporate by reference house rules or a facility handbook?

Does the contract spell out the consequences for violating their house rules?

Do any provisions in the contract seem to contradict or limit rights guaranteed residents under the Residents Rights contained in the personal care boarding home regulations?

Do any contract provisions waive or limit the facility's liability for lost or damaged personal possessions?

Do any contract provisions waive or limit the facility's liability for injury to the resident while in the care of the facility?

Does the contract require arbitration for the settlement of a claim against the facility? (There may be no exemption from the costs of arbitration for low income residents like that available in court proceedings where you can ask that filing fees be waived.)

Does the contract provide that the resident can be discharged for reasons other than (1) when the facility is no longer able to meet the resident's identified needs; (2) nonpayment for basic services, in accordance with the provider agreement; (3) failure of the resident to comply with written policies or rules of the facility which contain notice that discharge, transfer, or eviction may result from violation of such policy or rule; or (4) when a resident poses a danger to self or other residents?

Does the contract provide for written notice at least thirty (30) days in advance for any discharge initiated by the facility unless it is a medical emergency, necessary for the physical safety of the resident or others, or if due to nonpayment of rent, in which case notice should be given as soon as possible?

Does the contract contain a clear explanation of the residents' right to complain and the procedures for complaining (including the name, address, and phone number of agencies that can help with complaints)?

WHAT NEXT?

Although you can attempt to negotiate the terms of a contract with the facility, most facilities will not agree to a modification of terms in the contract. Therefore, if you have concerns about provisions in a contract you may be better off looking for a different facility. A

facility that uses an unreasonable contract may not be reasonable when it comes to resolving any problems that may arise. Even if you decide the benefits of the facility outweigh the drawbacks contained in the contract, by carefully examining the contract prior to signing it you will avoid being surprised later.

FOR LEGAL HELP

If you have concerns or questions regarding a contract you should seek legal help. If you are age 60 or older free legal assistance may be available to you through a Title III Legal Assistance Program. For a referral to the program nearest you may call your local Area Agency on Aging or the State Legal Services Developer at: (303) 722-0300 or 1-800-288-1376 (TDD for Hearing Impaired). If your income is low enough, you may qualify for assistance through your local Legal Services Corporation Program. Attorneys who practice in the areas of elder law, contracts, or landlord/tenant are also qualified to assist you.

FOR MORE INFORMATION ABOUT PERSONAL CARE BOARDING HOMES

If you have questions or concerns about a specific facility or about board and care facilities in general you can contact the Colorado Department of Public Health and Environment, Health Facilities Division or the state or local Ombudsman Program.

The Colorado Department of Public Health and Environment, Health Facilities Division can be reached at: (303) 692-2800. The State Ombudsman Program can be reached at: (303) 722-0300 or 1-800-288-1376 (TDD for Hearing Impaired). To reach your local Ombudsman contact the Area Agency on Aging in your region.

If the facility is an alternative care facility (Medicaid waiver program) you can contact Health Care Policy and Finance at: (303) 866-5908.

This pamphlet is published by The Legal Center for People with Disabilities and Older People. It provides general information based upon Colorado law and is not intended to be used as legal advice. Changes may have occurred in the law since the pamphlet was published. You may wish to obtain legal advice for your individual situation.

APPENDIX G

CONSUMER ISSUES IN ASSISTED LIVING

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*(Please note: This outline may not be completely up-to-date, as it was prepared Fall, 1999.
Some additions March 29, 2000)*

A. What is Assisted Living?

1. Housing (ranging from shared bedroom to luxurious apartment)
 - a. Range from group homes for fewer than five residents, to apartment-style complexes housing several hundred persons
 - b. Free-standing
 - c. Part of a continuing care retirement community
 - d. Part of skilled nursing facility.
2. Some degree of assistance with personal care needs
 - a. May include special units and/or services designed for residents with Alzheimers Disease and other forms of dementia.
3. Health care
4. Social and recreational opportunities
5. Protective oversight and monitoring, emphasis on individual needs and preferences.

B. Who Are the Providers?

1. Single individuals who care for others in their home
2. Private for-profit or not-for-profit organizations (including nursing homes)
3. Public entities
4. Large hotel chains such as Marriott and Hyatt.

C. Is Assisted Living Regulated?

1. Providers argue industry market-driven, market should direct what services provided and quality of those services; consumers could Avote with their feet.≡
2. In some states, not very different from traditional board and care -- a living unit. group meals and personal assistance -- but with increased living space and access to recreational activities, at higher cost, and with fewer legal protections for residents. In some states, may not be much different from a nursing home, either.
3. States are recognizing need for oversight, examining issues of regulation and quality assurance.¹ Issues include:
 - a. Is assisted living a housing, a medical, or a long term care model?
 - b. If it is housing, do landlord tenant laws apply?
 - c. If it is long term care, should nursing home standards govern?
 - d. Should the state restrict who can live in assisted living?
 - e. Who bears ultimate responsibility for ensuring resident safety?
 - f. Who monitors, enforces regulations?
4. What is the line between assisted living and nursing homes?
 - a. Resident needs?
 - b. Assisted living - relatively flexible regulatory scheme
 - c. Nursing home - comprehensive regulations and enforcement mechanisms

D. State Regulatory Approaches.

1. Renaming existing programs.

Some states have renamed as assisted living, or simply incorporated by reference, that which was previously known as residential care, personal care, board and care, domiciliary care, sheltered housing, adult congregate living or simply rest homes.

2. Creating new models.

Other states have created new statutory and regulatory schemes for the emergent models of assisted living, addressing issues such as:

¹The National Academy for State Health Policy found that by 1998, 22 states had implemented rules for assisted living, up from 15 in 1996. Robert L. Mollica, STATE ASSISTED LIVING POLICY: 1998 (1998).

- a. Living accommodations
- b. Admission and retention criteria
- c. Types and levels of services that may be provided

E. What About Resident Safety and Quality of Care?

- 1. Regulations establish general parameters, leave specifics to providers.
- 2. Rarely address supportive services are to be provided or quality assurance.
- 3. Provide few legal protections to residents.

F. Who Monitors Assisted Living?

- 1. Licensing agencies.
- 2. State Office on Aging, other state agencies.
- 3. Older Americans Act funded long-term care ombudsman program advocates on behalf of residents in nursing and board and care homes, and in some states, assisted living.²

G. Who is the Resident and What Does She Get for Her Money?

- 1. Demographic trends: increase in number of widows age 65 to 75; earlier discharges from acute care hospitals; call for more alternatives to nursing homes; emphasis on personal autonomy; desire to age in place.
- 2. Glossy advertisements offer home-like settings; exciting social opportunities; freedom from personal and health care worries; security of never having to move again.
- 3. Unit options may include: private apartments with cooking facilities and bath; single room or shared.
- 4. Supportive services: no uniform standards, little consistency among states. Some states have minimum standards for services that a facility must provide in order to be called assisted living, or to be licensed at a certain level of assisted living. In some states, services may be provided by facility as part of a comprehensive package, or by community program as needed.

²42 U.S.C. § 3002(f-h) (1992).

4. Health care and related services, ranging from light housekeeping, monthly wellness programs to comprehensive skilled nursing care.
 - a. State regulations versus expectations.
 - (i) E.g., health code requires licensed nurse to dispense medication, but assisted living regulations may not require licensed nurse on staff.

H. Admission and Retention

1. State criteria for admission varies.
 - a. Focus on resident needs
 - b. Extent to which assisted living facilities can meet those needs
2. Reasons for discharge.
 - a. Nonpayment of rent
 - b. Failure to comply with facility rules or policies
 - c. Posing a danger to self or others
 - d. Needing care that exceeds that which for the facility is licensed or has the capacity to provide.
3. Notice and right to challenge decision.
 - a. Some states require written notice (10 - 30 days) of intention to discharge
 - b. Very few give right to challenge decision. Of those few that do, most permit a resident to request an informal meeting within the facility or, more rarely, to appeal the decision outside the facility.

I. Consideration of Costs.

1. Depends on kind of facility and needs of resident. May include:

- a. Substantial entrance deposit, or none at all, plus
 - (i) basic rate for room and board, with all other services available *à la carte*, or
 - (ii) basic rate for room, board and a standard package of services, with other packages or additional services available at extra charge.
- 2. May vary within same facility.
 - a. 1993 AARP survey of 63 residences, only seven utilized a single rate within the same facility. The lowest median rate for room, board and services was \$995 per month, and the median highest rate was \$1,639 per month.³
 - b. Washington DC metropolitan area, fees for facilities with private suites and fine dining, or golf courses, exceeded \$5,000 per month in 1997. In the same area, group homes offered basic housing, meals and personal assistance at a cost of \$775 per month.⁴
- 3. Who pays?

Assisted living costs are generally paid out-of-pocket. Other arrangements include:

 - a. Supplemental Security Income state supplements for persons with mental or developmental disabilities, or Medicaid home and community based care waivers.
 - b. Medicare (skilled nursing care or services provided by licensed home health care agencies)
 - c. Long-term care insurance
 - d. Moderate fees under U.S. Department of Housing and Urban Development and the Federal Housing Administration (FHA), mortgage insurance to facilitate the development of board and care and assisted living facilities.⁵
 - e. Industry-sponsored affordability programs.

J. Finding the Balance Between Safety and Autonomy.

The philosophy of assisted living is to promote maximum independence for all residents. Resident and facility may negotiate agreements in which the resident waives certain services or protections and assumes certain risks, to promote

³Kane & Wilson, *supra* note 11, at 48.

⁴See Susan Levine, *Area Builders Target an Aging Population*, WASH. POST, Apr. 22, 1997, A1.

⁵12 U.S.C. §1715w

autonomy and individual choice of lifestyle. The agreement might release the facility from liability for resulting injury to resident. *Example:* a frail older resident might choose to leave the grounds for walks despite a risk of injury or disorientation. A resident might choose a diet or medication regime that is not in accordance with what the doctor recommends. A resident might choose to reside in a facility that cannot meet his/her actual care needs.

1. Does resident assume the risk?
 - a. Competent individual, aware of all her options and the consequences of her decisions, has the right to make such a choice. May have capacity to absolve facility from injury that results from choice.
 - b. Many residents lack decisional capacity to negotiate, or to assume the risk in this way, and may trade off important safeguards.
 - c. Residents or potential residents, their families and surrogates may be in an unequal bargaining position.
 - d. Opportunity for subtle coercion arising from fear of not being able to remain in the facility.
 - e. Choices in the changing field of assisted living may be unclear.
 - f. May be contrary to public policy to allow facility=s failure to protect a frail, elderly resident.
 - g. Relying on surrogates to agree to high risk circumstances can lead to abuse.
2. Very little litigation, courts may not look kindly upon a defense based on negotiated risk in an action for damages resulting from a facility=s failure to protect a frail elderly resident.⁶
3. Some states require, and many facilities conduct, pre-admission and follow-up assessments of residents in conjunction with the development of service plan. Some states have guidelines for development of so-called negotiated risk agreements.

⁶See *Klein v. BIA Hotel Corporation*, 41 Cal. App. 4th 1133, (1996); *Kotler v. Alma Lodge*, 74 Ca. Rep. 2d 721 (1998). In *Klein*, adult children sued a licensed Aresidential care facility= (assisted living) for wrongful death of their mother, who had suffered from depression and committed suicide while a resident. In *Kotler*, parents of two residents who died of heat prostration in a residential care facility for persons with mental illness sued the facility for wrongful death. In both cases, the courts found that the facility had a duty to exercise a reasonable standard of care in accordance with its licensure, including monitoring the physical and mental health of its residents and taking reasonable steps to keep residents safe. *Klein* was remanded for a determination of whether the facility actually breached that duty. In *Kotler*, the court affirmed the trial court=s finding of negligence and further found that, even though Alma Lodge stored and assisted residents with taking medications in accordance with its licensure, the facility was not a health care provider protected by state cap on noneconomic damages.

- a. Plan within the context of the services the facility is licensed and capable of providing; should not allow a facility to avoid legal responsibility
 - b. Take into account cognitive impairments that reduce resident ability to understand the choices and the risks involved
3. Adapting rules and procedures in order to meet a resident's needs could be reasonable accommodation under the Fair Housing Amendments Act or the Americans with Disabilities Act.
4. Consider part of collaborative, interactive approach to developing a plan for services and a lifestyle that are acceptable to the resident, within the facility's ability and legal responsibilities to meet resident needs according to state regulation and licensure.

K. Residency Agreement

1. Assisted living combines elements of long-term care and traditional housing, without being either a nursing home or rental housing, and (with the exception of Massachusetts) without giving residents the legal rights available to renters under state landlord-tenant laws, or those available to nursing home residents under federal or state laws.
2. State regulations vary on standards for admission and retention in assisted living, and facilities may be given broad discretion in how they choose to apply whatever standards and conditions do exist.
3. States are beginning to require consumer disclosures in assisted living agreements; none require that a particular document be used, that it be in a certain format, or that it be approved by the state.
4. Most states offer little incentive to develop a residency agreement that establishes the rights and responsibilities of the assisted living consumers and the provider.

L. Litigating Assisted Living Issues

1. Breach of contract
2. Consumer protection statutes

Minnesota v. Alterra Healthcare Corporation, Case No. _____, filed March 10, 2000. (Alleges deceptive trade practices, false advertising and consumer fraud)

Elder, et al., v. Fischer et al., __ N.E.2d __, 1998 WL 412423 (Ohio App.1 Dist., Jul. 24, 1998) (Ohio Consumer Sales Practice Act applies to the billing practices of a residential care facility).

3. Civil rights laws

a. The Fair Housing Amendments Act of 1988⁷ and the Americans with Disabilities Act⁸ prohibit discrimination on the basis of disability, or the perception of disability.⁹ Discriminatory action may include:

- Admissions criteria that screen out otherwise eligible protected persons
- House rules such as prohibitions on walkers or wheelchairs in common areas of the facility (e.g. the dining room or lobby)
- Guidelines that deny otherwise eligible residents the opportunity to participate in certain services because of their disabilities
- Requirements that disabled residents receive services in a setting that is segregated from other residents (where the segregation cannot be justified by the service being provided or circumstances of the individual involved).

b. Limits on protections. Facilities may deny admission to or discharge individuals who are not protected by these laws or who, even with accommodations, fail to meet program requirements, e.g., cannot afford the fees, or require care that the facility is not licensed to provide (assuming no waiver, other accommodation)

c. Discrimination between two groups of protected individuals. Reasonable accommodations allow provider to take into account

⁷42 U.S.C. §§ 3601 (1988). The FHAA prohibits discrimination in almost all housing activities or transactions, whether public or private sector; in the provision of services of facilities in connection with a dwelling; and in the application of zoning, land use or health and safety regulations.

⁸42 U.S.C. §§ 12101 (1990). The ADA applies to non-housing functions of a facility, such as meeting rooms, meal sites, adult day care, or long term care, under Title II (state and local programs) or Title III (public accommodations).

⁹ While age alone does not equate with disability, the protections of these laws are extended to those who, as a result of the aging process, are "frail," as described in the Older Americans Act as being 60 years of age or older, and unable to perform without assistance (e.g., verbal reminder, physical cue or supervision) at least two activities of daily living; or who, due to a cognitive or other mental impairment, require substantial supervision because of behavior that poses a serious health or safety hazard to self or others. 42 U.S.C. § 3002 (1992).

available resources and needs of the two groups. *Olmstead v. L.C.*
119 S.Ct. 2176 (June 22, 1999).

4. Landlord/tenant laws.

5. Tort law

Recent nursing home negligence cases are raising the issue of whether the Nursing Home Reform Law establishes the standard of care, leading to negligence per se claims for violations of regulatory standards.

6. Elder abuse law.

Are residential care facilities providers/caretakers subject to enhanced statutory penalties such as posthumous awards for pain and suffering and attorney fees? Yes says *Delaney v. Baker*, 69 Cal. Rptr.2d 645 (Cal. Ct. App. 1997), *rev. granted*, 72 Cal. Rptr.2d 216 (Cal. Feb. 25, 1998).

7. Medicaid waiver

Does the Medicaid waiver provide protections to a resident? Establish a cause of action?

8. Private right of action to enforce state law and/or regulations

M. Other Options for Resolving Disputes

1. Mediation

APPENDIX H

KING COUNTY LTC OMBUDSMAN PROGRAM
PO BOX 31151, SEATTLE WA 98103
TEL NO.: 206 623-0816 FAX NO.: 206 694-6776

authored by Mr. Brenton Phillips

RESIDENTS' PREFERENCES AND CHOICES
IN ADULT FAMILY HOMES

THE CUSTOMER CHOOSES

Compare long-term care to any other service or business where a customer is paying a provider from \$1,200 to \$6,000 [or more!] a month. Who has the power in these situations ; in a hotel, or a resort, for example, on a cruise ship or on a vacation? Who makes choices about services, their extent and timing; who chooses their food and meal times, their get-up and go-to-bed times, their activities, visitors, TV programs, their recreational and resting times? Is it necessary to give an answer? The paying customer does, of course. Why should it be different in long-term care facilities?

"Long-term care" involves a "care provider" and a "resident" in a power relationship with origins in the health system and a societal prejudice against its disabled and aging members. Frequently the provider assumes control over many aspects of a resident's life merely because they need "care," taking advantage of their dependent status, rather than respecting and treating them with courtesy and dignity, both as people and as their paying customers. Because residents are in need of personal care services, because they are older, or even because they have some cognitive impairment, does not entitle caregivers to control their lives.

PROMOTION OF RESIDENT RIGHTS

The Washington Long-Term Care Resident Rights law [RCW 70.129] applies to all residents of nursing homes, adult family homes and boarding homes with the intent that they should "have the opportunity to exercise reasonable control over life decisions."¹ Unfortunately, legislation does not change attitudes so deeply ingrained. When consumers [viz., residents and families alike] are aware of their power and their rights and feel able to exercise them, and providers have learnt to listen and respect their consumers, there will be the beginnings of a quality long-term care system. Part of that process is the educative and advocacy activity of LTC Ombudsmen and the attention to residents' personal concerns inherent in their work.

RCW 70.129.020 asserts it is the facility's responsibility to "*protect and promote the rights of each resident and assist the resident..*" and that "*the resident has the right to exercise his or her rights as a resident of the facility and as a citizen of the United States of America and the state of Washington,*" and "*has the right to be free of interference, coercion, discrimination, and reprisal from the facility for exercising his or her rights.*"

¹ RCW 70.129.005

ASSESSMENT

RCW 70.129.030(3) states that *"the facility shall not admit an individual before obtaining a thorough assessment of the resident's needs and preferences."*

The Adult Family Homes Minimum Licensing Requirements further details this, requiring that the written assessment include [WAC 388-76-61020(8), (10) and (11)] the resident's *"social, physical, and emotional needs,"* and *"preferences and choices regarding daily life that are important to the person (including, but not limited to, such preferences as the type of food that the person enjoys, what time he or she likes to eat, and when he or she likes to sleep),"* and *"preferences for activities."*

This assessment must also include *"a description of needs for which the client chooses not to accept services."*

NEGOTIATED CARE PLAN

The resident's stated needs and preferences must be included in the preliminary service plan [see WAC 388-76-61030] which must be completed by the qualified person making the assessment on a departmentally approved form, prior to admission. This preliminary service plan creates the foundation for the negotiated care plan, which is created between the provider and the resident [or resident's representative] within 14 days of admission. The resident must be involved *"to the greatest extent he or she is able to participate,"* along with *"the resident's family, if approved by the resident"* [see WAC 388-76-61530].

WAC 388-76-61500 details what must be included in the negotiated care plan, including *"the resident's activities preferences and how those preferences will be accommodated"* and *"other preferences and choices regarding issues important to the resident (including, but not limited to, food, daily routine, grooming), and what efforts will be made to accommodate those preferences and choices."*

WAC 388-76-61540 requires the negotiated care plan to be reviewed *"at least every twelve months, when there is a significant change in the resident's physical or mental condition,"* or *"at the resident's request."*

WAC 388-76-61520 concludes, *"the provider must implement the negotiated care plan after it has been agreed to and signed by the resident or the resident's representative, if the resident has a representative."*

FOOD

WAC 388-76-650 requires specifically the provider to serve food that *"takes into consideration the resident's preferences, caloric need"* and *"cultural and ethnic background."* The provider is required to *"obtain input from residents in meal planning and scheduling."*

ACTIVITIES

WAC 388-76-645 requires the provider to *"provide and promote opportunities for the resident to participate in activities of the resident's choice which are consistent with identified resident needs and functional capacity."*

GRIEVANCES

RCW 70.129.060 supports the resident right to *"voice grievances"* and to *"prompt efforts by the facility to resolve grievances the resident may have."*

LTC OMBUDSMAN'S ROLE

The provisions of RCW 70.129 and WAC 388-76 give ample backing to the LTC Ombudsman in advocating for residents in adult family homes. The LTCO may ask the resident or her/his representative whether a preference or choice has been asked of them and/or voiced to the provider, and whether it was included in the negotiated care plan. If it has not, it can be, and the provider must implement it.

If a care plan preference or choice has not been implemented, then the provider is obliged to address promptly any grievance raised by the resident or representative. This would include a care plan revision to address the issue of concern. There may be need for LTCO involvement in negotiations when resident and provider differ as to the practicality of meeting preference or choice.

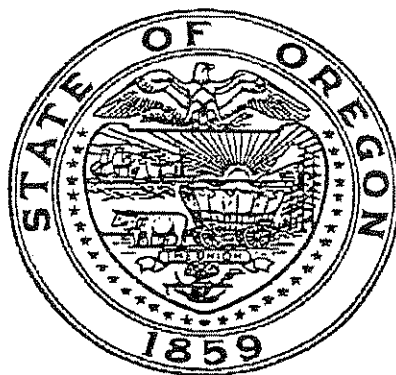
If the LTCO is not able to reach a result acceptable to the resident, then the above provisions give ample support for referral of a complaint to the DSHS against the provider for not meeting licensing and legal requirements.

APPENDIX I

ASSISTED LIVING FACILITIES

ADMINISTRATIVE RULES

Effective April 1, 1999



Department of Human Resources

Senior and Disabled Services Division

- (i) Food preparation, service and storage, if applicable; and
 - (j) Observation/reporting skills.
- (6) Staff shall comply with OAR Chapter 411, Division 009, Criminal History Clearance and OAR Chapter 333, Division 019, Health Division, Tuberculosis testing.

411-056-0020 Involuntary Move-Out Criteria

The Division encourages facilities to support a resident's choice to remain in his or her living environment while recognizing that some residents may no longer be appropriate for the assisted living setting due to safety and medical limitations.

- (1) A resident may, but is not required to be, asked to leave under the following circumstances:
 - (a) Residents shall be given 30 days written notice when they are requested to move-out for the following reasons:
 - (A) The resident's needs exceed the level of ADL services the facility provides. There shall be documentation of the facility's efforts to provide or arrange for the required services. The minimum required services identified in OAR 411-056-0015(3) shall be provided before a resident can be asked to move-out for this reason;
 - (B) The resident exhibits behavior or actions that repeatedly and substantially interferes with the rights or well being of other residents and the facility has tried prudent and reasonable interventions. There shall be documentation of the interventions attempted;
 - (C) The resident, due to severe cognitive decline, is not able to respond to verbal instructions, recognize danger, make basic care decisions, express need or summon assistance;
 - (D) The resident has a medical condition that is complex, unstable or unpredictable and treatment cannot be appropriately developed and implemented in the assisted living environment. There shall be documentation of the facility's efforts to obtain appropriate care for the resident; or
 - (E) Non-payment of charges.
 - (b) The resident may be asked to move-out with less than 30 days, but not less than 14 days written notice for the following reasons:
 - (A) The resident exhibits behavior that is an immediate danger to self or others;

- (B) The resident has had a sudden change in condition that requires medical or psychiatric treatment outside the facility and at the time the resident is to be discharged from that setting to move back into the facility, appropriate facility staff have re-evaluated the resident's needs and have determined the resident's needs exceed the facility's level of service. If the resident appeals the notification to move-out, the facility shall not rent the resident's unit pending completion of the appeals process;
 - (C) The facility is unable to accomplish resident evacuation in accordance with OAR 411-056-0035; or
 - (D) The resident requires 24 hour, seven day a week nursing supervision.
- (c) A resident or his/her legal representative may be given less than 14 days notice with written consent from the Division. All appeal rights shall remain intact.
 - (d) A resident or his/her legal representative shall be given at least 30 days notice if a facility has had its license revoked, not renewed, or voluntarily surrendered.
 - (e) A resident or his/her legal representative may terminate residency of a resident without notice due to abuse or conditions of imminent danger to life, health or safety, as substantiated by an SDSD/AAA office, or the Division.
- (2) The written move-out notice shall be completed on a Division approved form. The form shall be filled out in its entirety and a copy of the notice shall be sent by certified mail or delivered in person to the resident, the resident's legal representative, or any person designated by the resident, guardian, or conservator and if applicable, the case manager. Where a person lacks capacity and there is no legal representative, a copy of the notice to move-out shall be faxed or sent next-day delivery to the State Long Term Care Ombudsman, who may request an informal conference for the resident.
 - (3) Residents who are given 14 day or less, notification to move-out and who object to the requirement to move shall be given the opportunity of an informal conference if requested within five working days after receiving the notification. If notification is given under Section (1), Subsection (a) of this rule, the resident has ten days to object after receiving notification. When a resident or designee requests an informal conference, the Division shall be notified by the facility.
 - (4) The Division shall hold an informal conference as promptly as possible, but no later than seven working days after the request is received. Participants shall include the resident and others as requested by the resident. The purpose of the informal conference is to resolve the matter without a formal hearing. If a resolution is reached at the informal conference, no formal hearing will be held. If a resolution is not reached at the informal conference, the resident or resident's representative may request a formal hearing. The administrative hearing will be held within seven days from the request if the requirement to move has been given for the protection and welfare of the resident or other residents.
 - (5) The resident shall have the right to a formal administrative hearing prior to an involuntary

move-out.

- (6) Temporary absence for medical treatment is not considered a move-out.
- (7) Intra-facility move policy shall be included in the facility's disclosure statement. In the case of a facility requested move, the facility shall pay all associated costs with the move. Residents shall not be relocated from one unit to another for the convenience of the facility.

411-056-0030 Organization of Business

(1) Administrative Standards

- (a) The licensee shall be responsible for the operation of the facility.
- (b) Each licensed assisted living facility shall employ a full-time administrator.
- (c) The administrator is designated by the licensee as the person responsible for the daily operation of the facility and for the daily care provided in the facility.
- (d) The administrator shall appoint a staff member as designee to oversee the operation of the facility in the administrator's absence. The administrator or designee shall be in charge on site, at all times and shall ensure there are sufficient, qualified staff and the care, health and safety needs of the residents are met at all times.
- (e) The administrator shall maintain and post in public view the facility staffing plan and the name of the administrator or designee in charge shall be posted by shift.

(2) Administrator Qualifications

- (a) Facility administrators hired, or transferred between facilities, on or after April 1, 1999, shall meet the following requirements:
 - (A) Be at least 21 years of age;
 - (B) Possess a high school diploma or equivalent;
 - (C) Have two years successful experience providing care to persons in a community based or long term care setting or have a minimum of two years education in a health related field, or a combination thereof;
 - (D) Complete 40 hours of Division-approved training prior to operating an assisted living facility;
 - (E) Have 20 hours of documented Division-approved continuing education credits each year. The 40-hour Division-approved training fulfills the 20-hour continuing education requirement for the first year; and

**Assisted Living Facility
Notice of Move-Out**

*Oregon's
official form*

Name of Facility: _____
Address: _____
City/State/Zip: _____
Telephone: () _____ - _____ Fax: () _____ - _____

Notice Issued to: Last Name: _____ First Name: _____

Date of Proposed Move-out: _____ / _____ / _____

A. You are being requested to move **within 30 days** of receipt of this notice for the following reason(s):

- ☐ Your personal care (activity of daily living) needs exceed the level of services provided by the facility, as defined in writing by the facility prior to your admission.
- ☐ You have engaged in behavior that has repeatedly and substantially interfered with the rights or well being of others.
- ☐ You have experienced a severe cognitive decline resulting in an inability to respond to verbal instructions, recognize danger, make basic care decisions, express needs or summon assistance.
- ☐ You have a medical condition that is complex, unstable, or unpredictable and treatment cannot be developed and implemented in the facility.
- ☐ Non-Payment of charges owed to the facility.
- ☐ Termination of facility operations.

~ OR ~

B. You are being requested to move **within 14 days** of receipt of this notice for the following reason(s):

- ☐ You have exhibited behavior that is an immediate danger to self or others.
- ☐ A sudden change in your condition required treatment outside of the facility. Prior to being discharged from that setting, appropriate facility personnel re-evaluated your condition and determined that your needs exceed the facility's level of service, as defined in writing by the facility prior to your admission.
- ☐ You are unable to evacuate to a point of safety during fire drills in the required time. The facility has tried all prudent and reasonable accommodations to accomplish timely evacuation.
- ☐ You require 24 hour, seven days a week nursing supervision.

The specific reason(s) this action is being taken are: _____

If you object to this move, you have the right to an informal conference with Senior and Disabled Services Division (SDSD) and an administrative hearing. The purpose of an informal conference is to resolve the matter without going to a formal administrative hearing. If a resolution is not reached at the end of the informal conference, the resident or resident representative may request a formal hearing.

PLEASE READ: If you have been requested to move out for a reason checked in Section A, and wish an informal conference, you must request the conference ~~within~~ 10 days of receipt of this notice. If you have been requested to move out for a reason checked in Section B, and wish an informal conference, you must request the conference ~~within~~ 5 days of receipt of this notice.

If you would like to request an informal conference, please contact the facility administrator or the local SDSD or Area Agency on Aging office:

Address: _____ Tel: () _____ - _____

If you are having difficulty understanding this notice or your rights, or if you need an advocate to assist you at the informal conference, you may contact:

Long Term Care Ombudsman Office
3855 Wolverine NE, Suite 6
Salem, OR 97310
Tele: 1-800-522-2602 or (503) 378-6533 [378-5847 (TTY)]

Date

Signature and Title of Facility Representative

To be Completed by Facility:

Location to which resident is going: _____

Copies of this notice have also been issued to the following people and agencies:

Name/Relationship:

Address:

A copy of this notice must be sent to:

Senior and Disabled Services Division
Assisted Living Program
500 Summer St. NE, 2nd Floor
Salem, OR 97310-1015
1-800-232-3020 or (503) 945-5832
Fax: (503) 947-5046

SDSD
040199