

Making Nursing Home Care Great (Again):

Getting Your Loved Ones the Care They Deserve

Georgia NAELA
October 7, 2016

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One Person's Story

While I never saw anything as bad as the nursing home horror stories on the news, I know something about nursing home neglect. My poor Gigi, who was such a strong and confident woman, became a shell. She lost nearly 40 pounds that she didn't have to spare. She always said she wasn't hungry, but managed to eat if I fed her. I asked the staff several times if they couldn't please make it a point to have someone help her eat at least once a day. I was always told that they did the best they could and Gigi was eating as she should. I know that wasn't true. In the end, Gigi had less than 90 pounds on her 5'8" frame. She died of "natural causes" but I knew that wasn't true. She died for lack of attention, nutrition and entertainment. She died of boredom and starvation. *She died of embarrassment because she was too strong to ask for help eating.*¹ (Emphasis added)

¹ <http://www.medical-directions.com/worst-nursing-home-horror-stories/>

Mable Smith: A hypothetical nursing home resident

Mable is 76 years old. Her husband, John, died 2 years ago and shortly after his death Mable had a stroke. Mable was hospitalized briefly following her stroke and had a brief rehab stay. She then went to live with her daughter, Sally. Mable also has COPD, osteoporosis and arthritis. She has neuropathy in her feet.

Mable has 5 children. Four of them are supportive (Sally, Robert, Charles and Susan). One of them, Jacob, has a drug habit. About 4 years ago, Jacob stole Mable's identity and cleaned out her bank accounts.² He left Mable with nothing but her Social Security check, which is \$900 per month. She has no home. She has no retirement funds, but does have a pension check in the amount of \$1500 per month.³

Mable still has her mind, although she sometimes has difficulty speaking.⁴ She appointed Sally as her health agent to facilitate communication with her health care providers.

On March 21, 2014, Mable fell at home, fracturing her hip.⁵ She was taken to Saint Somewhere Memorial Hospital where she was admitted. The discharge planners have informed Sally that Mable will be discharged to a nursing home.

Mable has reached a point where she and her family must consider a potential transition along the care continuum. Mable is not "required" to agree with the hospital discharge planners. It's probably "smart" to consider their advice, but she could still go home if that's her choice. Mable's problem is that home care may no longer be sufficient to meet her needs. Leaving Mable with unmet needs places her in danger. It could also place a burden on Mable's children, especially while she is in rehabilitation. Decisions, possibly hard decisions, must be made.

² Jacob's theft was within the last 60 months. It must be disclosed if an application for Medicaid is filed, but Mable should not be penalized if she took sufficient action to recover her property. States vary regarding what constitutes sufficient action.

³ If the State has an income cap, Mable will likely need a qualified income trust.

⁴ Mable has capacity, so her preferences are paramount in considering placement. This also means any facility should communicate with her directly and consider her preferences.

⁵ Treatment will be required so this is not an "observation status" admission. This issue is discussed at: <http://www.medicareadvocacy.org/medicare-info/observation-status/>.

Brief History of Regulation

The history of federal regulation of nursing homes is reported in Appendix A of *Improving the Quality of Care in Nursing Homes* (Committee on Nursing Home Regulation, Institute of Medicine/National Academy Press 1986).

The federal government first became involved with nursing homes with the passage of the Social Security Act in 1935. However, little was done to assure quality care. By the 1950s and 1960s, concerns were expressed regarding the quality of care, culminating with the *Nursing Home Standards Guide*, issued in 1963. Still, this report focused on licensure, rather than quality of care for individual residents. Following passage of the Medicare and Medicaid Acts, pressure began to build in the 1970s to increase the standards for nursing homes participating in those programs. Among incidents reported were a front-page news with a fire that killed 32 residents in Ohio and a case of food-poisoning in Maryland that killed 36. In June 1971, with the White House Conference on Aging pending, President Nixon made a major speech deploring conditions in nursing homes and pledging to end federal payments to substandard facilities. Regulation was slow and mostly non-existent prior to appointment of the Institute on Medicine committee which reported on quality of care in 1986.

Following release of the IOM study,

[i]n 1987, Congress passed the Federal Nursing Home Reform Act ("FNHRA"), contained in the Omnibus Budget Reconciliation Act of 1987 ("OBRA '87"), Pub.L. No. 100-203, §§ 4201-4218, 1987 U.S.C.C.A.N. (101 Stat.) 1330, 1330-160 to -221 (codified at 42 U.S.C.A. §§ 1395i-3, 1396r), which provides for the oversight and inspection of nursing homes that participate in Medicare and Medicaid programs. The OBRA '87 amendments require that participants must be subjected to an unannounced "standard survey" at least once every fifteen months. 42 U.S.C.A. § 1395i-3(g)(2)(A). If a standard survey reveals that a nursing home is providing substandard care, the facility must undergo an "extended survey." 42 U.S.C.A. § 1395i-3(g)(2)(B). The requirements for certification include satisfying certain standards in areas such as "quality of care" and "resident rights." 42 U.S.C.A. §§ 1395i-3(g), 1396r(g). Additionally, the OBRA '87 amendments include a number of intermediate sanctions to encourage compliance with federal participation requirements. Specifically, Congress allowed for the denial of payments for all Medicare beneficiaries and all newly admitted Medicaid beneficiaries, civil monetary penalties under both Medicaid and Medicare for each day of non-compliance (not to exceed \$10,000 for each day of noncompliance under Medicare), appointment of temporary management, and, under

Medicaid, closure of the nursing home and transfer of residents to other facilities. 42 U.S.C.A. §§ 1395i- 3(h)(2)(B); 1396r(h)(2)(A), (h)(3). These enforcement measures are implemented by the Secretary of Health and Human Services and state governments. *See, e.g., United States v. Northern Health Facilities, Inc.*, 25 F.Supp.2d 690 (D.Md.1998).

Brogdon v. National Healthcare Corporation, 103 F. Supp 2d 1322 (N.D. Ga. 2000).

“OBRA '87 presented a paradigm shift in the way health care is regulated. Based on recommendations in the IOM report, the legislative mandate includes a framework for federal oversight emphasizing outcomes of care rather than ‘paper compliance’ with regulations.” J. Levine, *Introduction to the Nursing Home Industry*, in *Medical-Legal Aspects of Long-Term Care* (Lawyers & Judges Publishing Co. 2003).

See also T.G. Morford, *Nursing Home Regulation: History and Expectations*, Health Care Financing Review 1988 Supplement, p. 129.

The Law

Federal and State regulation of nursing home care can be divided into two (or possibly three) domains. First, federal and State regulation provides for resident dignity. The second domain, which can be subdivided, concerns health. The health domain focuses on the quality of care and on nursing home operations which contribute to the quality of health.

Federal Law - Nursing Home Reform Act of 1987: 42 USC 1395i & 42 USC 1396r

Federal Quality of Care Regulations: 42 C. F. R. 483.1 through .75

State Operations Manual: Appendix PP – Guidance to Surveyors for Long Term Care Facilities (Search note: Google “Appendix PP”)

Georgia Bill of Rights for Residents of Long-Term Care Facilities, O.C.G.A. § 31-8-100 through -127

Georgia Regulations (authorized by O.C.G.A. § 31-8-127), Ga. R. & Regs. 111-8-56-.01 through 111-8-56-.27

Licensure:

42 C.F.R. § 483.75(a)

A facility must be licensed under applicable State and local law.

Compliance with laws:

42 C.F.R. § 483.75(b)

The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.

O.C.G.A. § 31-8-101

The General Assembly finds that persons residing within long-term care facilities are isolated from the community and often lack the means to assert fully their rights as individual citizens. The General Assembly further recognizes the need for these persons to live within the least restrictive environment possible in order to retain their individuality and personal freedom. It is therefore the intent of the General Assembly to preserve the dignity and personal integrity of residents of long-term care facilities through the recognition and declaration of rights safeguarding against encroachments upon each resident's need for self-determination. It is the further intent of the General Assembly that this article complement and not duplicate or substitute for other survey and inspection programs regarding long-term care facilities.

O.C.G.A. § 31-8-122

(a) Each facility shall establish written policies and procedures in accordance with this article and shall provide for the implementation and continuing compliance with this article. In addition, each facility must comply with all other applicable state laws and regulations.

(b) Each facility shall conduct training for all staff on a quarterly basis to provide that its staff is familiar with this article and understands the obligation to provide care for residents consistent with this article at all times.

Generally, there is no express or implied private right to “enforce” the Nursing Home Reform Act or the underlying O.B.R.A. regulations. *See Brogdon et al. v. National Healthcare Corporation*, 103 F. Supp.2d 1322, 1330-1332 (N.D. Ga. 2000).⁶ This is true even though the Medicaid Act (the Nursing Home Reform Act) was enacted to benefit recipients and that the Act confers rights on the recipients. *Id.*, at 1330. Absent evidence that Congress intended to create a private right of enforcement, the Court in *Brogdon* refused to imply one. That, however, does not end the inquiry. Left for determination was whether Plaintiffs could sue as third party beneficiaries under the contract between the nursing facility and Medicaid, *Id.*, at 1334, and whether the O.B.R.A. regulations are relevant in determining the applicable standard of care. *Id.*, at 1342-1343.⁷ In *Brogdon*, the Court held that both of those issues turn on and would be resolved under State (Georgia) law. Other cases are as follows:

In *Nichols v. St. Luke Center of Hyde Park*, 800 F. Supp 1564 (S.D. Ohio 1992), a nursing home resident filed suit after he was involuntarily discharged. When he could not find alternate nursing home placement, he brought an action for injunctive relief, asserting a private right of action to enforce the discharge rules under the O.B.R.A. regulations. The Court rejected his claim, finding that O.B.R.A. does not confer a private right of action and finding further, that the nursing home “substantially complied” with the Act’s terms.⁸

In *Satterwhite v. Reilly*, 817 So.2d 407 (La. App. 2 Cir. 2002), the Court held that 42 C.F.R. 483.75 did not establish a standard of care with respect to a medical director.

⁶ See also *Tinder v. Lewis County Nursing Home District*, 207 F.Supp.2d 951 (E.D. Mo. 2001) (citing *Brogdon*).

⁷ “The Legislature and courts of the State of Georgia are empowered to determine applicable professional standards of care in this State. If these standards of care reflect or incorporate federal Medicaid and Medicare participation requirements – or even the standard of care applied in a foreign country – neither the principle of federalism nor the principle that foreign governments cannot legislate for the citizens of the State of Georgia are offended. In other words, the content of the applicable standard of care is simply a matter of state law.” *Brogdon*, 1342-43. Use of the statute in defining the applicable standard of care is consistent with the Restatement of the Law, Second, Torts, § 288B.

⁸ In other words, this is an instance where bad facts make bad law.

There, Plaintiff's case went to trial on the issue of whether Dr. Reilly acted negligently as the nursing home medical director.⁹ The Plaintiff failed to prove the appropriate standard of care; mere citation to the federal regulations is insufficient.¹⁰ *See also Pack v. Crossroads, Inc.*, 53 S.W.3d 492 (Tex. App. 2001) (violation of non-penal administrative code does not support negligence per se claim); and *Laurie v. Patton Home for the Friendless*, 516 P.2d 76 (Or. 1973) (failure to charge negligence per se based on violation of city ordinance sufficient attendants to provide protection and care was not error).

Nonetheless, the Nursing Home Reform Act and the O.B.R.A. regulations may provide the applicable standard of care. In *McMccain v. Beverly Health and Rehabilitation Services, Inc.*, 2002 WL 1565526 (E.D. Pa. July 15, 2002) (a pressure ulcer case), citing Sections 286 and 288 of the *Restatement of Torts 2d*, the Court held that an absence of a private right of action under O.B.R.A. does not end the inquiry. "A statute may still be used as the basis for a negligence per se claim when it is clear that, despite the absence of a private right of action, the policy of the statute will be furthered by such a claim because its purpose is to protect a particular group of individuals." *Id.*, at *19.

⁹ Specifically, Plaintiff alleged that Dr. Reilly failed to participate in any meetings, care plan reviews, review of minimum data sets, incident reports and failed to address the needs of the facility, thus violating 42 CFR 483.75(i). Plaintiff further alleged that Reilly failed to implement policies relating to fall prevention, proper hygiene, proper nutrition, hydration, infection control and medical attention.

¹⁰ The Court reached the same result with respect to 42 CFR 483.40(a), noting that the Plaintiff offered no expert testimony to establish the standard of care. A similar issue appears in *Makas v. Hillhaven*, 589 F.Supp. 736 (M.D. N.C. 1984), where the "Plaintiff identified none of its witnesses as experts and represented to the Court that she did not intend to offer any expert testimony on the applicable standard of care [... instead, contending] that the Nursing Home Patient's Bill of Rights established the standard of care." Query whether the result would have been different if a qualified expert testified that the O.B.R.A. regulations establish the standard of the care? *See also Raney ex rel. Estate of Raney v. Ashford Hall*, 2002 WL 14354 (Tex. App. Dallas 2002) (declining to find that a documented violation of state and federal statutes and regulations constitutes negligence per se).

Resources

20 Common Nursing Home Problems and How to Resolve Them, available at: http://www.justiceinaging.org/20-common-nursing-home-problems/?utm_source=JIA&utm_medium=homepage&utm_campaign=20%20Common

S. Burger, **Nursing Homes: Getting Good Care There** (Available on Amazon)

National Consumer Voice, www.theconsumervoice.org

Medicare.gov, **Nursing Home Compare**

Kaiser Family Foundation, **Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2009-2014** (August 2015), at <http://ltcombudsman.org/uploads/files/library/deficiencies-09-14.pdf>

The Centers for Medicare and Medicaid Services (CMS) created its Nursing Home Compare website in 1998. The following synopsis outlines its history and information currently available on the website:¹¹

The CMS created the *Nursing Home Compare* website in 1998. Since the creation of the website, DNH has regularly increased the amount information available to beneficiaries and their families about quality of care in nursing homes. In 2002, the Quality Measures and Health Assessment Group added 10 quality measures (QMs) to *Nursing Home Compare*, increasing the number of QMs to 18. In 2005, DNH expanded the Nursing Home Compare website to include Life Safety Code inspection results. In 2007, DNH began publishing the names of nursing homes that are a part of a more intense monitoring program for selected nursing homes with a history of performance issues. Further explanation of this monitoring program (called the Special Focus Facility program) can be found on page 15 of this document.

In 2008, we unveiled the *Nursing Home Compare Five-Star Quality Rating System*. This rating system was developed to help individuals, family members, and the public compare the quality of nursing homes more easily by synthesizing a large volume of information on the website into a more easily viewable star rating system. The website can be found at:

¹¹ CMS Survey and Certification Group 2016/2017 Nursing Home Action Plan, available at <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Downloads/2016-2017-Nursing-Home-Action-Plan.pdf>.

<https://www.Medicare.gov/NHCompare/Home.asp>. CMS based the ratings on an algorithm that calculates a composite view of nursing homes from three measures: results from approximately three years of onsite inspections carried out by trained surveyors; performance on certain quality measures; and self-reported nursing staffing levels. CMS continuously seeks to improve the usefulness of the information on our websites. In 2009, CMS began structured surveys to obtain and analyze systematic information about how users search and employ the new information, the perceived strengths and limits of the website, and the overall usefulness of the website. CMS has also regularly conducted focus group sessions with consumers who have gone through nursing home searches. These focus groups provide important feedback about the usability and understandability of *Nursing Home Compare*.

In 2012, CMS made additional improvements to *Nursing Home Compare*. These included adding 7 additional quality measures derived from MDS 3.0 data, providing the full text of surveyors' deficiency findings, reporting the names of individual owners of nursing homes, and reporting on enforcement actions that CMS has taken against nursing homes. In 2015, CMS made improvements to the *Five Star Quality Rating System* by adding two quality measures to the 5-star calculation (short-stay and long-stay usage of antipsychotic medications), improving calculations for staffing levels, and reflecting higher standards for nursing homes to achieve a high rating on all measures publicly reported in the quality measures dimension on the website.

The DNH is also continuing to evaluate additional quality measures for nursing homes, particularly measures of hospitalization, discharge to community, and functional status improvement in both short- and long-stay nursing home residents. CMS will continue to regularly update and modify *Nursing Home Compare* to make the website easier to use and understand.

CMS continues to provide an easily searchable and downloadable copy of *Nursing Home Compare* data on the data.medicare.gov website. The data.medicare.gov site is suitable for regulators, researchers, quality improvement leads, and other individuals who have a need to download nursing home data. Data.medicare.gov also contains archives of *Nursing Home Compare* data for researchers who want to look at longitudinal trends.

Hospital Discharge Planning

When a hospital patient is being discharged,¹² advocacy should begin with discharge plan. A discharge plan should consider those factors necessary to make a successful transition from one care setting to another. According to 42 C.F.R. 482.43:

(1) The hospital must provide a discharge planning evaluation to the patients identified in paragraph (a) of this section, and to other patients upon the patient's request, the request of a person acting on the patient's behalf, or the request of the physician.

(2) A registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise the development of, the evaluation.

(3) The discharge planning evaluation must include an evaluation of the likelihood of a patient needing post-hospital services and of the availability of the services.

(4) The discharge planning evaluation must include an evaluation of the likelihood of a patient's capacity for self-care or of the possibility of the patient being cared for in the environment from which he or she entered the hospital.

(5) The hospital personnel must complete the evaluation on a timely basis so that appropriate arrangements for post-hospital care are made before discharge, and to avoid unnecessary delays in discharge.

(6) The hospital must include the discharge planning evaluation in the patient's medical record for use in establishing an appropriate discharge plan and must discuss the results of the evaluation with the patient or individual acting on his or her behalf.

Discharge planning serves several functions. First, it can serve to facilitate a Medicare covered transition to a skilled nursing home. Medicare coverage opens doors, creating choice regarding nursing home placement. The reason is because the Medicare rate is higher than the Medicaid rate. Second, discharge planning forces the hospital to focus on Mable's needs, to develop an assessment regarding the level of care needs, and to plan proactively to meet her needs, either by maintaining or improving health. As ample literature shows, hospital employees are often better paid; as a result, they are better trained to anticipate and plan for Mable's needs. Mable and her family should avail herself of this expertise. Third, the discharge plan is one method of communicating Mable's continuing needs to the nursing home. The discharge plan must be placed in the medical record. Accordingly, it is available to the nursing home as the SNF develops a continuing care plan.

As the discharge plan proceeds, the family should learn as much as it can about nursing home options.

¹² <https://www.caregiver.org/hospital-discharge-planning-guide-families-and-caregivers>.

Nursing Home Statistics and Data

CMS's Nursing Home Data Compendium 2015 Edition¹³ provides a significant amount of data regarding nursing home operations.

In the fourth quarter of 2014, **15,634 nursing homes** participated in the Medicare and Medicaid programs, almost identical to the number in 2013 (N=15,638). Generally the number of nursing homes has gradually declined over the past 10 years, but this decline has essentially halted over the past five years .

The results in Section 3 of the Compendium represent four “snapshots” of the US nursing home population – on December 31 of each year 2011 to 2014. Just over 1.4 million residents were living in US nursing homes on December 31, 2014, corresponding to 2.6 % of the over-65 population and 9.5 % of the over-85 population. Slightly more than fifteen percent (15.5%) of the nursing home population is under age 65, while 7.8 % are over 95 years. Women constitute nearly two-thirds (65.6 %) of the nursing home population, and nearly 4 of 5 nursing home residents (77.9 %) are non-Hispanic Whites.

Both cognitive and functional impairment are common among nursing home residents. However, nearly 1 in 5 (19.8%) had no Activities of Daily Living (ADL) impairment and more than one-third (38.7%) had no more than mild cognitive impairment; further 11.1% had no ADL impairment and little or no cognitive impairment. The most impaired – those with 5 ADL impairments as well as severe cognitive impairment represent 14.9% of the nursing home population.

Many residents report at least some pain in the last 5 days, with 12.2 % reporting moderate or severe pain and frequent pain and an additional 22.3% reporting pain that is mild or infrequent. However, the percentage reporting moderate or severe pain has declined somewhat over the past four years; it was 15.3% in 2011. A recent fall resulting in injury has been experienced by 5.3% of residents and an additional 11.0% of residents have had a non-injurious fall. Both injurious and non-injurious falls are more common among those with greater cognitive impairment.

More than one-third of residents (34.3%) are severely incontinent of bowel and/or bladder. Pressure ulcers of Stage 2 or greater were present in 5.1% of nursing home residents, a ten percent decline since 2011 (5.9%). Physical restraint use has become quite rare, with 1.0% of residents having any restraints in the past 7 days. Antipsychotic use, however, is quite common, with more than 1 out of 5 residents (21.7%) receiving an antipsychotic medication at least once in the past 7 days.

¹³ https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Downloads/nursinghomedatacompendium_508-2015.pdf.

Admissions

Sally is concerned because she knows her mother. At Mable's insistence, Sally promised she would never admit Mable to a nursing home. The rehab stay following the stroke 2 years ago was a nightmare for Mable. She hated it. But the medical staff at Saint Somewhere insist that nursing home care is the only way Mable's needs will be met. The hospital discharge planners believe it is unlikely Mable will return home.

With the assistance of the hospital discharge planners, Sally finds an available bed at Mercy Me Nursing Center. Sally recalls a friend had problems with another local facility, Dewey Cheatum Nursing Center, and wants to avoid problems related by that friend. Hopefully Mercy Me will be better.

42 U.S.C. § 1396r(c)(5)

42 C.F.R. § 483.12(d)

(1) The facility must—

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

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

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

Appendix PP, F208

Mable is admitted on physician orders.

42 C.F.R. § 483.20(a) (a) Admission orders. At the time each resident is admitted, the facility must have physician orders for the resident's immediate care.

42 U.S.C. § 1396r(c)(5)(B)(ii)

Subparagraph (A)(ii) shall not be construed as preventing a facility from requiring an individual, who has legal access to a resident's income or resources available to pay for care in the facility, to sign a contract (without incurring personal financial liability) to provide payment from the resident's income or resources for such care.

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O.C.G.A. § 31-8-106(a) through (d)

(a) At the time of admission, the facility must provide the resident with:

- (1) A written notice of the facility's basic daily or monthly rates;
- (2) A written statement of all facility services, including those offered on a needed basis, and related charges, including any extra charges for services not covered under Medicare or Medicaid or by the facility's basic daily or monthly rate;
- (3) A statement disclosing the facility's name and business address and the name and business address of the administrator of the facility. Upon request an applicant or resident shall be furnished with a copy of the annual disclosure statement filed with the Department of Community Health; and
- (4) Notice of the right of access to the written policies and procedures of the facilities. Access to these policies and procedures shall be permitted during ordinary business hours.

(b) Upon a resident's request, the facility must provide that resident with a current list of all services and charges. Current charges must be posted in a conspicuous location.

(c) The facility must inform each resident in writing, at least 30 days in advance of the effective date, of any changes in rates or the services that these rates cover.

(d) A facility must bill for charges at least once a month unless otherwise agreed. Each bill must itemize charges for:

- (1) The daily or monthly rate; and
- (2) All extra charges.

O.C.G.A. § 31-8-107

Each resident or person requesting admission to a facility shall be free from discrimination by the facility through its refusing admission or continued residency on the basis of the resident's or applicant's history or condition of mental or physical disease or disability, unless such admission would cause the facility or any resident to lose eligibility for any state or federal program of financial assistance or unless the facility cannot provide adequate and appropriate care, treatment, and services to the resident due to such disease or disability.

Ga. R. & Regs. § 111-8-56-.05(4)

A home shall admit only those patients for which it can provide needed care and only if the home has a permit covering that type of care. When a patient develops a condition requiring care of a level or type not provided at that home, the administration shall arrange for transfer of the patient to another home, hospital or home health agency which has a permit or is certified to provide such care or shall make satisfactory arrangements for the needed care if the condition is to be of short duration.

Paying for Nursing Home Care

The cost of future care has Mable and Sally concerned. They have many questions.

They heard something about “100 Days” of nursing home care being paid for by Medicare. After the 100 days, they aren’t sure what happens.

Medicaid

They recall Mable’s sister, Sarah, going to a nursing home in another State. The cost was more than \$200 per day. Sarah, a retired government employee, had significant monthly income.

They recall hearing that Sarah needed some sort of trust because her monthly income was too high.

One of Sally’s neighbors told Sally that she heard you have to have assets out of your name for months or years. Sally’s neighbor also told her that the State can seize your home after you die. All of this is very confusing.

The primary hypothetical assumes Mable is already impoverished. She might need a qualified income trust if the State has an income cap. Unless her application is delayed, she will also need to disclose her son’s theft because it will fall within 60 months of her Medicaid application. She will need to demonstrate that she did not intend to transfer assets for less than fair market value. Medicaid planning is complex. There is no one-size-fits-all solution because each individual or couple’s circumstances are different. Medicaid planning is further complicated because property, contract and other rights vary from case to case and from State to State. When planning is done for non-traditional or blended families, planning must account not only for Medicaid eligibility, but must consider the future expectations of current partners and disappointed heirs. Planning can consist of spending down, giving assets away and accepting the consequences of gifting, converting countable assets into exempt assets, converting countable assets into income, marital planning, and usually includes consideration of estate recovery. Planning should also consider the tax impact of a proposed transaction and how it might affect other participants in the transaction. Ethical planning should also focus on Mable’s needs (and John’s needs if he is living) before any consideration is given to inheritance planning for their children.

Hypothetical Two

Assume the same facts as Hypothetical One except that Mable’s husband, John, is alive and healthy. John has Social Security income of \$1,200 per month. John and Mable own a home titled as joint tenants with rights of survivorship. Assume John and Mable have

a basic estate plan and their desire is to leave their assets to their children in equal shares.

Hypothetical Three

Same facts as Hypothetical Two, except that John and Mable have a stock portfolio valued at \$150,000. They have cash assets (e.g., checking, savings and certificates of deposit) valued at \$200,000.

Sally asks the admissions coordinator to explain how Medicaid works. The admissions coordinator says no one at the facility understands Medicaid. They just fill out the forms, send them in, and see what happens.

42 C.F.R. § 483.10(b)(5)

The facility must— (i) Inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of— (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each resident when changes are made to the items and services specified in paragraphs (5)(i) (A) and (B) of this section.

42 C.F.R. § 483.10(b)(10)

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

The admissions coordinator indicates Mable must private pay while her Medicaid application is pending.

“A resident cannot be transferred for non-payment if he or she has submitted to a third party payor all the paperwork necessary for the bill to be paid.” CMS State Operations Manual, Appendix PP, p. 44 (this language moved to pdf page 58 in the move recent online edition).

When Sally indicates that Mable doesn't own a home the admissions coordinator tells Sally that she must sign a personal guaranty.

42 C.F.R. § 483.12(d)

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

personal financial liability, to provide facility payment from the resident's income or resources.

Appendix PP, Interpretive Guidelines for § 483.12(d)(2), indicates the prohibition on third party guarantees applies to all residents regardless of payment source.

The admissions coordinator tells Sally that the nursing home will balance bill Mable for the difference between the Medicaid rate and the private pay rate.

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

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

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

The admissions coordinator informs Sally that Mable needs to sign over Mable's house to secure payment.

42 C.F.R. § 483.10(c)(1) (1) The resident has the right to manage his or her financial affairs, and the facility may not require residents to deposit their personal funds with the facility.

Quality of Life

A nursing home resident does not lose his or her rights by virtue of being admitted to the home. There is a reason individuals admitted to a nursing home are called “residents” instead of “patients.” Quality of life, not just quality of care, is a critical factor in maintaining one’s psychosocial wellbeing. As the statutes and regulations in this paper indicate, a nursing facility must address all of a person’s needs (physical, mental and psychosocial), must address resident preferences, and must make reasonable accommodations.

Holistic care. The nursing home regulations envision whole-person care. In other words, care is deficient if the nursing home creates a hostile or consistently unpleasant environment, even if medical treatment is satisfactory.

Example: John is a resident at Happy Acres Nursing Home. Although John’s medical and nursing needs have been addressed, the charge nurse routinely visits John’s room and threatens to prevent his family from visiting. She also takes his cell phone to prevent him from communicating with family or with the ombudsman.

42 U.S.C. § 1396r(b)(1)(A)

A nursing facility must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident.

42 C.F.R. § 483.15(a)

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

Appendix PP, F241

“Dignity” means that in their interactions with residents, staff carries out activities that assist the resident to maintain and enhance his/her self-esteem and self-worth. Some examples include (but are not limited to):

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

- Promoting resident independence and dignity in dining such as avoidance of:
 - Day-to-day use of plastic cutlery and paper/plastic dishware;
 - Bibs (also known as clothing protectors) instead of napkins (except by resident choice);
 - Staff standing over residents while assisting them to eat;
 - Staff interacting/conversing only with each other rather than with residents while assisting residents;
- Respecting residents' private space and property (e.g., not changing radio or television station without resident's permission, knocking on doors and requesting permission to enter, closing doors as requested by the resident, not moving or inspecting resident's personal possessions without permission);
- Respecting residents by speaking respectfully, addressing the resident with a name of the resident's choice, avoiding use of labels for residents such as "feeders," not excluding residents from conversations or discussing residents in community settings in which others can overhear private information;
- Focusing on residents as individuals when they talk to them and addressing residents as individuals when providing care and services;
- Maintaining an environment in which there are no signs posted in residents' rooms or in staff work areas able to be seen by other residents and/or visitors that include confidential clinical or personal information (such as information about incontinence, cognitive status). It is allowable to post signs with this type of information in more private locations such as the inside of a closet or in staff locations that are not viewable by the public. An exception can be made in an individual case if a resident or responsible family member insists on the posting of care information at the bedside (e.g., do not take blood pressure in right arm). This does not prohibit the display of resident names on their doors nor does it prohibit display of resident memorabilia and/or biographical information in or outside their rooms with their consent or the consent of the responsible party if the resident is unable to give consent. (This restriction does not include the CDC isolation precaution transmission-based signage for reasons of public health protection, as long as the sign does not reveal the type of infection);
- Grooming residents as they wish to be groomed (e.g., removal of facial hair for women, maintaining the resident's personal preferences regarding hair length/style, facial hair for men, and clothing style). NOTE: For issues of failure to keep dependent residents' faces, hands, fingernails, hair, and clothing clean, refer to Activities of Daily Living (ADLs), Tag F312;
- Maintaining resident privacy of body including keeping residents sufficiently covered, such as with a robe, while being taken to areas outside

their room, such as the bathing area (one method of ensuring resident privacy and dignity is to transport residents while they are dressed and assist them to dress and undress in the bathing room).

- NOTE: For issues of lack of visual privacy for a resident while that resident is receiving ADL care from staff in the bedroom, bathroom, or bathing room, refer to §483.10(e), Privacy and Confidentiality, Tag F164. Use Dignity F241 for issues of visual privacy while residents are being transported through common areas or are uncovered in their rooms and in view of others when not receiving care; and
- Refraining from practices demeaning to residents such as keeping urinary catheter bags uncovered, refusing to comply with a resident's request for toileting assistance during meal times, and restricting residents from use of common areas open to the general public such as lobbies and restrooms, unless they are on transmission-based isolation precautions or are restricted according to their care planned needs. An exception can be made for certain restrooms that are not equipped with call cords for safety.

O.C.G.A. § 31-8-103

Residents' rights shall include, but not be limited to, the rights provided in Code Sections 31-8-104 through 31-8-121.

O.C.G.A. 31-8-111

Each resident shall be encouraged and assisted by the facility to exercise all rights, benefits, and privileges as a citizen including, but not limited to, the following:

(1) The right to vote. Residents who are eligible to vote shall have the right to vote in primary, special, and general elections and in referendums. The facility shall permit and reasonably assist residents to obtain voter registration forms, applications for absentee ballots, and absentee ballots and to comply with other requirements which are prerequisites for voting;

(2) The right to free exercise of religion as well as freedom from imposition of religious beliefs or practices;

(3) The right to associate, meet, and communicate privately with persons of the resident's choice; and

(4) The right to participate, inside and outside the facility, in social, family, religious, and community group activities.

Suspension of certain rights:

O.C.G.A. § 31-8-117

Only the rights enumerated in paragraph (6) of subsection (b) of Code Section 31-8-108 and subsections (b), (c), and (d) of Code Section 31-8-112 may be suspended as a result of medical contraindication, as determined by the resident's physician, and then only under the following conditions:

- (1) The physician has personally examined the resident and the physician documents

that the exercise of such right or rights pose a danger to other residents or an immediate and substantial danger to the resident himself. If the threatened danger is only to the resident, the resident's rights shall not be suspended pursuant to this Code section, provided the resident or guardian understands the danger and insists on the exercise of the right;

(2) Prior to or at the time of a suspension of a right or rights due to a medical contraindication, the resident and his guardian or representative shall be notified of such suspension, its duration, and the resident's legal right to meet with legal counsel, the ombudsman provided for in Article 3 of this chapter, members of his family, his guardian, or others of his choice; and

(3) Suspension of a right or rights shall be for a reasonable time period, which period shall not exceed 35 days for skilled nursing residents and not to exceed 65 days for intermediate care residents. Every additional period, which periods shall also not exceed the same maximum time periods, shall be considered a new suspension, subject to the conditions of paragraphs (1) and (2) of this Code section.

O.C.G.A. § 31-8-118(a)

The facility must permit each resident to exercise the rights and pursue the interests described in this chapter without restraint, interference, coercion, discrimination, or reprisal from the facility.

Right to a Dignified Existence

Recent UK Survey: "The most important thing nurses provide to nursing home patients are dignity, personhood and quality of life, but training in these aspects of care is lacking.... Nursing degree programs don't adequately prepare nurses for their specialized role in care homes, researchers found. ... "RNs working with older residents in nursing homes can promote dignity by understanding what is important to residents and their families when being cared for[.]" "Responding to residents' wishes will enhance their sense of wellbeing, self-esteem and ultimately their quality of life." K. Doyle, Care home nurses need training for unique role (Reuters September 26, 2016).¹⁴

42 C.F.R. § 483.10

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

42 C.F.R. § 483.15(a)

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

Appendix PP, F241

42 C.F.R. § 483.15(b)

The resident has the right to -

- (1) Choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care;
- (2) Interact with members of the community both inside and outside the facility; and
- (3) Make choices about aspects of his or her life in the facility that are significant to the resident.

Appendix PP, F242

Waking times and bedtimes:

O.C.G.A. § 31-8-112(b)

Each resident shall be permitted to rise and retire at times of his choice, if the resident does not interfere with the rights of others.

¹⁴ <http://www.reuters.com/article/us-health-nursing-training-idUSKCN11W211>.

Tobacco and alcohol use:

O.C.G.A. § 31-8-112(c)

Unless contradictory to written admission policies of which the resident, guardian, or representative is informed prior to admission, each resident shall be permitted to use tobacco and to consume alcoholic beverages, subject to the facility's policies and safety rules and applicable state law, if the resident does not interfere with the rights of others.

Right to come and go:

O.C.G.A. § 31-8-112(d)

Each resident shall be free to enter and leave the facility as the resident chooses.

Personal property:

O.C.G.A. § 31-8-113

(a) Each resident shall be permitted to retain and use his personal property, including funds and clothing, in his immediate living quarters as space permits.

(b) Upon request, the facility shall provide a means of securing the resident's property in his room or in any other secured part of the facility so long as the resident has access to such property on weekdays and, where facility policy allows, on weekends and holidays. Each facility shall keep a record of all personal property deposited within a secured part of the facility.

(c) The facility shall develop procedures for investigating complaints concerning thefts of residents' property and shall promptly investigate all such complaints and report the results of its investigation to the complainant.

See also M. Oosterveld-Vlug, et al., *Nursing Home Staff's Views on Residents' Dignity: A Qualitative Interview Study*, 13 BMC Health Serv. Res. 353 (2013), at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3850947/>

Notice and Explanation of Rights

42 C.F.R. § 483.10(b)(1)

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

Appendix PP, F156

This requirement is intended to assure that each resident know his or her rights and responsibilities and that the facility communicates this information prior to or upon admission, as appropriate during the resident's stay, and when the facility's rules change.

"In a language that the resident understands" is defined as communication of information concerning rights and responsibilities that is clear and understandable to each resident, to the extent possible considering impediments which may be created by the resident's health and mental status. If the resident's knowledge of English or the predominant language of the facility is inadequate for comprehension, a means to communicate the information concerning rights and responsibilities in a language familiar to the resident must be available and implemented. For foreign languages commonly encountered in the facility locale, the facility should have written translations of its statements of rights and responsibilities, and should make the services of an interpreter available. In the case of less commonly encountered foreign languages, however, a representative of the resident may sign that he or she has explained the statement of rights to the resident prior to his/her acknowledgement of receipt. For hearing impaired residents who communicate by signing, the facility is expected to provide an interpreter. Large print texts of the facility's statement of resident rights and responsibilities should also be available.

"Both orally and in writing" means if a resident can read and understand written materials without assistance, an oral summary, along with the written document, is acceptable.

Any time State or Federal laws relating to resident rights or facility rules change during the resident's stay in the facility, he/she must promptly be informed of these changes.

“All rules and regulations” relates to facility policies governing resident conduct. A facility cannot reasonably expect a resident to abide by rules he or she has never been told about. Whatever rules the facility has formalized, and by which it expects residents to abide, should be included in the statement of rights and responsibilities.

O.C.G.A. § 31-8-104

Each resident and his guardian or representative, if the resident does not have a guardian, shall be given by the facility a written and oral explanation of the rights, grievance procedures, and enforcement provisions provided for by this article before or at the time of admission to a long-term care facility. Written acknowledgment of the receipt of such explanation by the resident and his guardian or representative shall be made a part of the resident's file. In addition, each facility shall post written notices of such rights in conspicuous locations in the facility. Such written notices shall be prepared by the department. The notices shall be prepared in type and format which is easily readable by residents and shall describe residents' rights, grievance procedures, and enforcement provisions provided for by this article.

Exercise of Rights

42 U.S.C. § 1396r(c)(1)(C)

In the case of a resident adjudged incompetent under the laws of a State, the rights of the resident under this subchapter shall devolve upon, and, to the extent judged necessary by a court of competent jurisdiction, be exercised by, the person appointed under State law to act on the resident's behalf.

42 C.F.R. § 483.10(a)

A facility must protect and promote the rights of each resident, including each of the following rights:

(a) Exercise of rights.

- (1) The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.
- (2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights.
- (3) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under State law to act on the resident's behalf.
- (4) In the case of a resident who has not been adjudged incompetent by the State court, any legal-surrogate designated in accordance with State law may exercise the resident's rights to the extent provided by State law.

Appendix PP, F152, regarding 483.10(a)(1): Exercising rights means that residents have autonomy and choice, to the maximum extent possible, about how they wish to live their everyday lives and receive care, subject to the facility's rules, as long as those rules do not violate a regulatory requirement.

Appendix PP, F153, regarding 483.10(a)(2): This regulation is intended to protect each resident in the exercise of his or her rights. The facility must not hamper, compel, treat differentially, or retaliate against a resident for exercising his/her rights. Facility behaviors designed to support and encourage resident participation in meeting care planning goals as documented in the resident assessment and care plan are not interference or coercion. Examples of facility practices that may limit autonomy or choice in exercising rights include reducing the group activity time of a resident trying to organize a residents' group; requiring residents to seek prior approval to distribute information about the facility; discouraging a resident from hanging a religious ornament above his or

her bed; singling out residents for prejudicial treatment such as isolating residents in activities; or purposefully assigning inexperienced aides to a resident with heavy care needs because the resident and/or his/her representative, exercised his/her rights.

Free Choice and Fully Informed

42 U.S.C. § 1396r(c)(1)(A)(i)

A nursing facility must protect and promote the rights of each resident, including each of the following rights:

The right to choose a personal attending physician, to be fully informed in advance about care and treatment, to be fully informed in advance of any changes in care or treatment that may affect the resident's well-being, and (except with respect to a resident adjudged incompetent) to participate in planning care and treatment or changes in care and treatment.

42 C.F.R. § 483.10(b)(3)

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

Appendix PP, regarding 483.10(b)(3):

“Total health status” includes functional status, medical care, nursing care, nutritional status, rehabilitation and restorative potential, activities potential, cognitive status, oral health status, psychosocial status, and sensory and physical impairments. Information on health status must be presented in language that the resident can understand. This includes minimizing use of technical jargon in communicating with the resident, having the ability to communicate in a foreign language and the use of sign language or other aids, as necessary. (See §483.10(d)(3), F175, for the right of the resident to plan care and treatment.)

42 C.F.R. § 483.10(b)(4)

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

Appendix PP, F154, regarding 483.10(a)(3) & (4):

When reference is made to “resident” in the Guidelines, it also refers to any person who may, under State law, act on the resident's behalf when the resident is unable to act for himself or herself. That person is referred to as the resident's surrogate or representative. If the resident has been formally declared incompetent by a court, the surrogate or representative is whoever was appointed by the court - a guardian, conservator, or committee. The facility should verify that a surrogate or representative has the necessary authority. For example, a court-appointed conservator might have the power to make financial decisions, but not health care decisions.

A resident may wish to delegate decision-making to specific persons, or the resident and family may have agreed among themselves on a decision-making process. To the degree permitted by State law, and to the maximum extent practicable, the facility must respect the resident's wishes and follow that process.

The rights of the resident that may be exercised by the surrogate or representative include the right to make health care decisions. However, the facility may seek a health care decision (or any other decision or authorization) from a surrogate or representative only when the resident is unable to make the decision. If there is a question as to whether the resident is able to make a health care decision, staff should discuss the matter with the resident at a suitable time and judge how well the resident understands the information. In the case of a resident who has been formally declared incompetent by a court, lack of capacity is presumed. Notwithstanding the above, if such a resident can understand the situation and express a preference, the resident should be informed and his/her wishes respected to the degree practicable. Any violations with respect to the resident's exercise of rights should be cited under the applicable tag number.

The involvement of a surrogate or representative does not automatically relieve a facility of its duty to protect and promote the resident's interests. For example, a surrogate or representative does not have the right to insist that a treatment be performed that is not medically appropriate, and the right of a surrogate or representative to reject treatment may be subject to State law limits.

42 C.F.R. § 483.10(d)

The resident has the right to—

- (1) Choose a personal attending physician;
- (2) Be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being; and
- (3) Unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, participate in planning care and treatment or changes in care and treatment.

Appendix PP, F163

The right to choose a personal physician does not mean that the physician must or will serve the resident, or that a resident must designate a personal physician. If a physician of the resident's choosing fails to fulfill a given requirement, such as §483.25(l)(1), Unnecessary drugs; §483.25(l)(2), Antipsychotic drugs; or §483.40, frequency of physician visits, the facility will have the right, after informing the resident, to seek alternate physician participation to assure provision of appropriate and adequate care and treatment. A facility may not place barriers in the way of residents choosing their own physicians. For example, if a resident does not have a physician, or if the resident's physician becomes

unable or unwilling to continue providing care to the resident, the facility must assist the resident in exercising his or her choice in finding another physician. Before consulting an alternate physician, one mechanism to alleviate a possible problem could involve the facility's utilization of a peer review process for cases which cannot be satisfactorily resolved by discussion between the medical director and the attending physician. Only after a failed attempt to work with the attending physician or mediate differences in delivery of care should the facility request an alternate physician when requested to do so by the resident or when the physician will not adhere to the regulations.

If it is a condition for admission to a continuing care retirement center, the requirement for free choice is met if a resident is allowed to choose a personal physician from among those who have practice privileges at the retirement center.

A resident in a distinct part of a general acute care hospital can choose his/her own physician, unless the hospital requires that physicians with residents in the distinct part have hospital admitting privileges. If this is so, the resident can choose his/her own physician, but cannot have a physician who does not have hospital admitting privileges.

If residents appear to have problems in choosing physicians, determine how the facility makes physician services available to residents.

O.C.G.A. § 31-8-108(b)(1)

In the provision of care, treatment, and services to the resident by the facility, each resident or guardian shall be entitled to the following: (1) To choose the resident's physician. The physician so chosen shall inform the resident in advance whether or not the physician's fees can be paid from public or private benefits to which the resident is entitled and shall provide such documentation as may be required by law or regulation.

O.C.G.A. § 31-8-108(b)(1)

In the provision of care, treatment, and services to the resident by the facility, each resident or guardian shall be entitled to the following: (6) To obtain from the resident's physician or the physician attached to the facility a complete and current explanation concerning the resident's medical diagnosis, treatment, and prognosis in language the resident can understand. Each resident shall have access to all information in the medical records of the resident and shall be permitted to inspect and receive a copy of such records unless medically contraindicated. The facility may charge a reasonable fee for duplication, which fee shall not exceed actual cost.

Change in Condition

42 C.F.R. § 483.10(b)(11)

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

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

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

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

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

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

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

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

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

Appendix PP, F157

For purposes of §483.10(b)(11)(i)(B), life-threatening conditions are such things as a heart attack or stroke. Clinical complications are such things as development of a stage II pressure sore, onset or recurrent periods of delirium, recurrent urinary tract infection, or onset of depression. A need to alter treatment “significantly” means a need to stop a form of treatment because of adverse consequences (e.g., an adverse drug reaction), or commence a new form of treatment to deal with a problem (e.g., the use of any medical procedure, or therapy that has not been used on that resident before).

In the case of a competent individual, the facility must still contact the resident's physician and notify interested family members, if known. That is, a family that wishes to be informed would designate a member to receive calls. Even when a resident is mentally competent, such a designated family member should be notified of significant changes in the resident's health status because the resident may not be able to notify them personally, especially in the case of sudden illness or accident.

The requirements at §483.10(b)(1) require the facility to inform the resident of his/her rights upon admission and during the resident's stay. This includes the resident's right to privacy (§483.10(e), F164). If, after being informed of the right to privacy, a resident specifies that he/she wishes to exercise this right and not notify family members in the event of a significant change as specified at this requirement, the facility should respect this request, which would obviate the need to notify the resident's interested family member or legal representative, if known. If a resident specifies that he/she does not wish to exercise the right to privacy, then the facility is required to comply with the notice of change requirements.

In the case of a resident who is incapable of making decisions, the representative would make any decisions that have to be made, but the resident should still be told what is happening to him or her.

In the case of the death of a resident, the resident's physician is to be notified immediately in accordance with State law.

The failure to provide notice of room changes could result in an avoidable decline in physical, mental, or psychosocial well-being.

O.C.G.A. § 31-8-108(b)(5)

In the provision of care, treatment, and services to the resident by the facility, each resident or guardian shall be entitled to the following: (5) To have any significant change in the resident's health status reported to persons of his choice by the facility within a reasonable time.

Refuse Treatment

On July 5, 2016, the Georgia Supreme Court decided *Doctors Hospital of Augusta v. Alicea*, 2016 Ga. LEXIS 448 (2016). There, the Court affirmed lower court decisions denying a motion for summary judgment. As part of its decision, the Court interpreted the Georgia Advanced Directive Act, O.C.G.A. § 31-32-1 et seq., holding that it is the will of the patient or her designated agent, and not the will of the health care provider, that controls health decisions. *Alicea* is the most recent Georgia case reviewing the right to refuse treatment.

On November 12, 2009, Bucilla Stephenson executed an advance directive naming Jacqueline Alicea, her granddaughter, as health agent. Stephenson was 89 years old at the time. The advance directive specified that Alicea was authorized to make health care decisions for Stephenson in accordance with what Alicea determined Stephenson's best interest. The advance directive also said: "My agent shall make health-care decisions for me in accordance with this power of attorney for health care, any instructions I give in this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health-care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent."

Stephenson repeatedly told her family that she was ready to go when the good Lord called her. "When it's my time, it's my time, don't prolong it." Stephenson specifically told her agent she did not want to rely on a machine to live, including a ventilator. Another family member had died on a ventilator, with Alicea making the decision to remove life support and Stephenson had not wanted to put her granddaughter through that decision-making process again.

Two years passed before Stephenson's health declined. She was taken to the hospital around February 28, 2012 when Alicea thought Stephenson was having a stroke. Alicea brought Stephenson's advance directive with her.

Numerous tests were performed, with Alicea inquiring about her grandmother's condition. At each juncture, Alicea indicated that her grandmother did not want to be intubated and did not want to be placed on a ventilator. At least one doctor charted that Alicea was to be contacted before CPR was performed and before Stephenson was intubated.

On Monday, March 5, 2012, a physician requested consent for a surgical thoracentesis, which was a procedure to drain fluid from Stephenson's lung cavity. The physician had not read Stephenson's advance directive or the progress notes charted by the other physician. He did not inform Alicea that the procedure required intubation or the use of a ventilator. If he had provided that information, then Alicea would not have consented

to the surgery. During the surgery, the physician discovered that much of Stephenson's right lung was necrotic (dead) and removed approximately two-thirds of the lung. Stephenson was extubated in the recovery room. Alicea was not informed that her grandmother had been intubated and placed on a ventilator for the procedure.

Two days later, Stephenson experienced respiratory distress during early morning hours. Around 4am, nursing staff called the physician. The physician made the decision to place Stephenson on a ventilator. When the nursing staff questioned whether to call Alicea first, the physician rebuffed them saying "I'm not going to call her at six o'clock in the morning and scare the hell out of her. I'll wait till, you know, she wakes up and then I'm going to call her and tell her what happened." No effort was made to contact Alicea before Stephenson was intubated.

Around 8am that morning, Alicea's husband stopped by the hospital and discovered Stephenson was on a ventilator. He called his wife, who immediately came to the hospital demanding to know why her instructions were disregarded. It took the nursing staff approximately 15 to 20 minutes to locate a copy of the advance directive in Stephenson's file and, when they did, one nurse remarked "Boy, somebody really messed up."

On March 14, Stephenson's kidney's began shutting down. A new physician recommended taking Stephenson off of the ventilator, which was done. Comfort measures were provided and Stephenson died three days later, on March 17, 2012. On May 14, 2013, Alicea filed a lawsuit against the hospital and the physician who intubated Stephenson, and who placed her on the ventilator. The lawsuit alleged that Stephenson was caused unnecessary pain and suffering, contrary to her advance directive for health care and the specific directions of Alicea, her designated health care agent. The complaint alleged breach of agreement, professional and ordinary negligence, medical battery, intentional infliction of emotional distress, and breach of fiduciary duty. When discovery concluded, the defendants filed a motion for summary judgment, alleging they were immune from civil prosecution because the immunity provisions in the Advanced Directive Act protected them.

The trial court rejected the defendants' arguments and denied the motion for summary judgment. The defendants appealed. The Court of Appeals also rejected the defendants' arguments and affirmed the trial court. The defendants appealed. The Georgia Supreme Court then accepted the defendants' petition for certiorari. On appeal, a unanimous Supreme Court affirmed the trial court and the court of appeals, finding that there is no immunity unless the health care provider acts in good faith to follow the patient's decision, or the decision of her health agent, or unless the provider informs the patient or health agent that it cannot follow the decision on moral grounds and immediately cooperates to facilitate a transfer to a health care provider who will follow the patient's decision.

In reaching its conclusion, the Court examined the statute and the uncodified preface to the 2007 statute. There it stated: “The General Assembly has long recognized the right of the individual to control all aspects of his or her personal care and medical treatment, including the right to insist upon medical treatment, decline medical treatment, or direct that medical treatment be withdrawn.” The Court held this means “a clear objective of the Act is to ensure that in making decisions about a patient's health care, it is the will of the patient or her designated agent, and not the will of the health care provider, that controls.”

As part of its decision, the Court gave the following instruction regarding how health decisions are made:

The Act then sets forth several rules for how decisions are to be made in caring for a patient with an advance directive. If the patient's attending physician determines in good faith that the patient is able to understand the general nature of the health care procedure being consented to or refused, the patient's own decision about that procedure prevails over contrary instructions by a health care agent. See OCGA § 31-32-7 (a). However,

[w]henver a health care provider believes a declarant is unable to understand the general nature of the health care procedure which the provider deems necessary, the health care provider shall consult with any available health care agent known to the health care provider who then has power to act for the declarant under an advance directive for health care.

OCGA § 31-32-8 (1). In addition, with respect to the withholding or withdrawal of life-sustaining procedures or nourishment and hydration, the health care agent's directions prevail over the patient's written instructions in the advance directive, unless the advance directive specifies otherwise. See OCGA § 31-32-14 (d). The health care agent also has priority over any other person, including a guardian, to act for the patient in matters covered by the advance directive, unless the directive says otherwise. See OCGA § 31-32-14 (e).

So, was the physician acting in good faith, attempting to follow the patient's wishes as expressed herself or by her health agent? For purposes of the motion for summary judgment, the Court found he was not.

“The health care decision in question is the decision to intubate Stephenson and put her on a ventilator as a life-prolonging measure around 4:00 a.m on the morning of March 7, 2012. Although there is evidence to the contrary, there is ample evidence that in ordering that procedure, Dr. Catalano was not acting in good faith reliance — in honest dependence — on any decision Alicea had made as Stephenson's health care agent, either to comply with it or to refuse or fail to comply with it and then promptly inform Alicea of his unwillingness. Instead, the

evidence would support a finding that Dr. Catalano made the health care decision himself, in the exercise of his own medical and personal judgment. By his own account, when he directed the on-duty doctor to intubate Stephenson, he was not considering the stuff of advance directives and health care agents — “any of the code/no code/do not intubate/resuscitate”; he decided himself “what's right for the patient,” and would check with Alicea later to see if she wanted to “undo” the procedure he was ordering and “pull the tube out.” See footnote 3 above. Dr. Catalano even rebuffed a nurse's question about calling Alicea before ordering the intubation, saying that he would call her later “and tell her what happened.”

The Court declined to comment on the ultimate outcome of the case, or on other disputes among the parties. However, it's guidance regarding the use of an advance directive is instructive. The patient or her agent is in charge when making health decisions. Summary Judgment was denied.

42 C.F.R. § 483.10(b)(4)

The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive.

42 C.F.R. § 483.10(b)(8)

The facility must comply with the requirements specified in subpart I of part 489 of this chapter relating to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.

Appendix PP, F155

The intent of this requirement is that the facility promotes these rights by:

- Establishing and maintaining policies and procedures regarding these rights;
- Informing and educating the resident about these rights and the facility's policies regarding exercising these rights;
- Helping the resident to exercise these rights; and
- Incorporating the resident's choices regarding these rights into treatment, care and services.

NOTE: While the language of 42 C.F.R. **§483.10(b)(8)** applies only to adults, states may have laws that govern the rights of parents or legal guardians of children to formulate an advance directive. The CMS believes that this is an important issue for the parents/guardians of terminally ill or severely disabled children. Therefore surveyors are encouraged to refer to state law in cases where concerns arise regarding advance directives in non-adult populations. The regulatory language found under 42 C.F.R. **§483.10(b)(4)** applies to all residents, regardless of age.

DEFINITIONS

“Advance care planning” is a process used to identify and update the resident’s preferences regarding care and treatment at a future time including a situation in which the resident subsequently lacks capacity to do so. For example, when life-sustaining treatments are a potential option for care and the resident is unable to make his or her choices known.

“Advance directive” means, according to 42 C.F.R. §489.100, a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated. Some States also recognize a documented oral instruction.

“Cardiopulmonary resuscitation (CPR)” refers to any medical intervention used to restore circulatory and/or respiratory function that has ceased.

“Durable Power of Attorney for Health Care” (a.k.a. “Medical Power of Attorney”) is a document delegating authority to an agent to make health care decisions in case the individual delegating that authority subsequently becomes incapacitated.

“Experimental research” refers to the development, testing and use of a clinical treatment, such as an investigational drug or therapy that has not yet been approved by the FDA or medical community as effective and conforming to accepted medical practice.

“Health care decision-making” refers to consent, refusal to consent, or withdrawal of consent to health care, treatment, service, or a procedure to maintain, diagnose, or treat an individual’s physical or mental condition.

“Health care decision-making capacity” refers to possessing the ability (as defined by State law) to make decisions regarding health care and related treatment choices.

“Investigational or experimental drugs” refer to new drugs that have not yet been approved by the FDA or approved drugs that have not yet been approved for a new use, and are in the process of being tested for safety and effectiveness.

“Life-sustaining treatment” is treatment that, based on reasonable medical judgment, sustains an individual’s life and without it the individual will die. The term includes both life-sustaining medications and interventions (e.g., mechanical ventilation, kidney dialysis, and artificial hydration and nutrition). The term does not include the administration of pain medication or other pain management interventions, the performance of a medical procedure related to enhancing comfort, or any other medical care provided to alleviate a resident’s pain.

“Legal representative” (e.g., “Agent,” “Attorney in fact,” “Proxy,” “Substitute decision-maker,” “Surrogate decision-maker”) is a person designated and authorized by an advance directive or State law to make a treatment decision for another person in the event the other person becomes unable to make necessary health care decisions.

“Treatment” refers to interventions provided to maintain or restore health and well-being, improve functional level, or relieve symptoms.

OVERVIEW

Traditionally, questions of care were resolved at the bedside through decision-making by an individual, his or her family and health care practitioner. As technological advances have increased the ability of medicine to prolong life, questions have arisen concerning the use, withholding, or withdrawing of increasingly sophisticated medical interventions.

The Federal Patient Self - Determination Act contained in Public Law 101-508 is the authority on an individual's rights and facility responsibilities related to Advance Directives. The right of an individual to direct his or her own medical treatment, including withholding or withdrawing life-sustaining treatment, is grounded in common law (judge-made law), constitutional law, statutory law (law made by legislatures) and regulatory mandates governing care provided by facilities. Several landmark legal decisions have established an enduring judicial precedence for the legal principles of advance directives and the right to refuse or withhold treatment.

These legal developments have influenced standards of professional practice in the care and treatment of individuals in health care facilities. Several decades of professional debate and discussion have simultaneously advanced the thinking on these matters and promoted implementation of pertinent approaches to obtaining and acting on patient/resident wishes.

ESTABLISHING AND MAINTAINING POLICIES AND PROCEDURES REGARDING THESE RIGHTS

The facility is required to establish, maintain, and implement written policies and procedures regarding the residents' right to formulate an advance directive, refuse medical or surgical treatment and right to refuse to participate in experimental research. In addition, the facility is responsible for ensuring that staff follow policies and procedures.

The facility's policies and procedures delineate the various steps necessary to promote and implement these rights, including, for example:

- Determining on admission whether the resident has an advance directive and, if not, determining whether the resident wishes to formulate an advance directive;
- Determining if the facility periodically assesses the resident for decision-making capacity and invokes the health care agent or legal representative if the resident is determined not to have decision-making capacity;
- Identifying the primary decision-maker (e.g., assessing the resident's decision-making capacity and identifying or arranging for an appropriate legal representative for the resident assessed as unable to make relevant health care decisions);
- Defining and clarifying medical issues and presenting the information regarding relevant health care issues to the resident or his/her legal representative, as appropriate;

- Identifying, clarifying, and periodically reviewing, as part of the comprehensive care planning process, the existing care instructions and whether the resident wishes to change or continue these instructions;
- Identifying situations where health care decision-making is needed, such as a significant decline or improvement in the resident's condition;
- Reviewing the resident's condition and existing choices and continuing or modifying approaches, as appropriate;
- Establishing mechanisms for documenting and communicating the resident's choices to the interdisciplinary team; and
- Identifying the process (as provided by State law) for handling situations in which the facility and/or physician do not believe that they can provide care in accordance with the resident's advance directives or other wishes on the basis of conscience.

INFORMING AND EDUCATING THE RESIDENT ABOUT THESE RIGHTS

The facility is required (by 42 C.F.R. §489.102 Requirements for Providers) to provide, at the time of a resident's admission, written information concerning the resident's rights to make decisions concerning medical care, including the right to refuse medical or surgical treatment, decline to participate in experimental research and the right to formulate advance directives. The resident must also receive a written description of the facility's policies that govern the exercise of these rights.

ESTABLISHING ADVANCE DIRECTIVES

The facility must ensure compliance with Federal and State requirements regarding advance directives. At the time the resident is admitted to a nursing home, staff must determine whether the resident has executed an advance directive or has given other instructions to indicate what care he or she desires in case of subsequent incapacity. Such a directive or instructions could be a living will, a directive to the attending physician, a durable power of attorney for health care, a medical power of attorney, a pre-existing medical order for "do not resuscitate (DNR)," or another document that directs the resident's health care. Several States have also adopted the use of a portable and enduring order form that documents the resident's choices related to life-sustaining treatments.

If the resident or the resident's legal representative has executed one or more advance directive(s), or executes one upon admission, it is important that copies of these documents be obtained, incorporated and consistently maintained in the same section of the resident's medical record readily retrievable by any facility staff, and that the facility communicate the resident's wishes to the resident's direct care staff and physician. If the resident has not executed an advance directive, the facility is required to advise the resident and family of the right to establish an advance directive as set forth in the laws of the State; to offer assistance if the resident wishes to execute one or more directive(s); and to document in the resident's medical record these discussions and any advance

directive(s) that the resident executes. The resident has the option to execute advance directives, but cannot be required to do so. As required by 42 C.F.R. §489.102(a)(3), the facility may not condition the provision of medical care or discriminate against a resident based on whether he or she has executed an advance directive.

Advance Care Planning

In order for a resident to exercise his or her right to make knowledgeable choices about care and treatment or to decline treatment, the primary care provider and facility staff should provide information (in a language and terminology that the resident understands) to the resident and/or his/her legal representative regarding the resident's health status, treatment options, and expected outcomes. Whether or not the resident chooses to execute an advance directive, discussion and documentation of the resident's choices regarding future health care should take place during the development of the initial comprehensive assessment and care plan and periodically thereafter. The process of having such discussions, regardless of when they occur, is sometimes referred to as "advance care planning."

The process of advance care planning is ongoing and affords the resident, family and others on the resident's interdisciplinary health care team an opportunity to reassess the resident's goals and wishes as the resident's medical condition changes. Advance care planning is an integral aspect of the facility's comprehensive care planning process and assures re-evaluation of the resident's desires on a routine basis and when there is a significant change in the resident's condition. The process can help the resident, family and interdisciplinary team prepare for the time when a resident becomes unable to make decisions or is actively dying.

The ability of a dying person to control decisions about medical care and daily routines has been identified as one of the key elements of quality care at the end of life. Advance care planning is a method to further a resident's control over his or her own medical treatment and choices.¹⁰ It also allows the decision-maker (whether it is the resident, family or other legal representative) to be better informed about the treatment alternatives available in a variety of circumstances.

RIGHT TO REFUSE MEDICAL OR SURGICAL TREATMENT

If a resident (directly or through an advance directive) declines treatment (e.g., refuses artificial nutrition or IV hydration, despite having lost considerable weight), the resident may not be treated against his/her wishes. If a resident is unable to make a health care decision, a decision by the resident's legal representative to forego treatment may, subject to State requirements, be equally binding on the facility. A facility may not transfer or discharge a resident for refusing treatment unless the criteria for transfer or discharge are otherwise met. If a resident's refusal of treatment results in a significant change in condition, the facility should reassess the resident and modify the care plan as appropriate. The facility is expected to assess the resident for decision-making capacity and invoke the health care agent or legal representative if the resident is determined not to

have decision-making capacity. Once the decision-making capacity is assessed, the facility is expected to determine and document what the resident is refusing, to assess the reasons for the resident's refusal, to advise the resident about the consequences of refusal, to offer pertinent alternative treatments, and to continue to provide all other appropriate services. The resident's refusal of treatment does not absolve a facility from providing other care that allows him/her to attain or maintain his/her highest practicable physical, mental and psychosocial well-being. For example, a facility would still be expected to provide appropriate measures for pressure ulcer prevention, even if a resident has refused food and fluids and is expected to die.

CARDIOPULMONARY RESUSCITATION (CPR)

Facilities must not implement a facility-wide "no CPR" policy as this policy may prevent implementation of a resident's advance directives and does not meet professional standards of quality as required in §483.20(k). The American Heart Association (AHA) publishes guidelines every five years for CPR and Emergency Cardiovascular Care (ECC). These guidelines reflect global resuscitation science and treatment recommendations. In the guidelines, AHA has established evidenced-based decision-making guidelines for initiating CPR when cardiac arrest occurs in or out of the hospital. AHA urges all potential rescuers to initiate CPR unless: 1) a valid DNR order is in place; 2) obvious signs of clinical death (e.g., rigor mortis, dependent lividity, decapitation, transection, or decomposition) are present; or 3) initiating CPR could cause injury or peril to the rescuer.¹¹ AHA guidelines for CPR provide the standard for the American Red Cross, state Emergency Medical Services, healthcare providers, and the general public.

If a resident experiences a cardiac arrest, facility staff must provide basic life support, including CPR, prior to the arrival of emergency medical services, and:

- in accordance with the resident's advance directives, or
- in the absence of advance directives or a Do Not Resuscitate order; and
- if the resident does not show obvious signs of clinical death.

Prompt initiation of CPR is essential as brain death begins four to six minutes following cardiac arrest if CPR is not initiated within that time.

Additionally, CPR certified staff must be available at all times. Staff must maintain current CPR certification for healthcare providers through a CPR provider whose training includes hands-on skills practice and in-person assessment and demonstration of skills; online-only certification is not acceptable. Resuscitation science stresses the importance of properly delivered chest compressions to create blood flow to the heart and brain. Effective chest compressions consist of using the correct rate and depth of compression and allowing for complete recoil of the chest¹³. Proper technique should be evaluated by an instructor through in-person demonstration of skills. CPR certification which includes an online knowledge component yet still requires in-person skills demonstration to obtain certification or recertification is also acceptable.

Presence of a facility-wide “no CPR” policy interferes with a resident’s right to formulate an advance directive and should be cited at §483.10(b)(4) and (8), Rights Regarding Treatment and Advance Directives, F155. For concerns related to provision of CPR and CPR certification of staff, the survey team should also consider §483.20(k)(3), Services Provided Meet Professional Standards, F281 and §483.75, Effective Administration for Resident Well-Being, F490.

RIGHT TO DECLINE TO PARTICIPATE IN EXPERIMENTAL RESEARCH

The resident has the right to refuse to participate in experimental research. A resident being considered for participation in experimental research must be fully informed of the nature of the experimental research (e.g., medication, other treatment) and the possible consequences of participating. The resident must give informed consent in order to participate. If the resident is incapable of understanding the situation and of realizing the risks and benefits of the proposed research, but a legal representative gives proxy consent, the facility has a responsibility to ensure that the proxy consent is properly obtained and that essential measures are taken to protect the individual from harm or mistreatment. The resident (or his/her legal representative if the resident lacks health care decision-making capacity) must have the opportunity to refuse to participate both before and during the experimental research activity.

A facility participating in any experimental research involving residents must have a process for committee (e.g., an Institutional Review Board) approval of this research and mechanisms in place for its oversight. In this regard, §483.75(c), Relationship to Other HHS Regulations, applies (i.e., research conducted at a facility must adhere to 45 CFR Part 46, Protection of Human Subjects of Research).

O.C.G.A. § 31-8-108(b)(3)

In the provision of care, treatment, and services to the resident by the facility, each resident or guardian shall be entitled to the following: (3) To refuse medical treatment, dietary restrictions, and medications for the resident. The resident or guardian shall be informed of the probable consequences of such refusal, the refusal shall be noted in the resident's medical records, and the resident's attending physician shall be notified as soon as practical. If such refusal apparently would be seriously harmful to the health or safety of the resident, the facility shall either refer the resident to a hospital or notify a responsible family member or, if such a family member is not readily available, the county department of family and children services. If such refusal would be harmful to the health or safety of others, as documented in the resident's medical records by the resident's physician, this subsection shall not apply. Any facility or employee of such facility which complies with this paragraph shall not be liable for any damages resulting from such refusal.

Accommodation of Needs

42 U.S.C. § 1396r(c)(1)(A)(v)

A nursing facility must protect and promote the rights of each resident, including each of the following rights:

The right—

(I) to reside and receive services with reasonable accommodation of individual needs and preferences, except where the health or safety of the individual or other residents would be endangered, and

(II) to receive notice before the room or roommate of the resident in the facility is changed.

42 C.F.R. § 483.15(e)

A resident has the right to -

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

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

Appendix PP, F246

“Reasonable accommodations of individual needs and preferences,” means the facility’s efforts to individualize the resident’s physical environment. This includes the physical environment of the resident’s bedroom and bathroom, as well as individualizing as much as feasible the facility’s common living areas. The facility’s physical environment and staff behaviors should be directed toward assisting the resident in maintaining and/or achieving independent functioning, dignity, and well-being to the extent possible in accordance with the resident’s own needs and preferences.

O.C.G.A. § 31-8-118(b)

The facility must exercise judgment in situations which pose a threat to the health or safety of a resident, and when necessary, must achieve a reasonable accommodation of conflicting rights of residents.

Visitation

One day, after a care plan meeting, someone on the care team approached Sally. Apparently Charles tried to stop by the other night to visit Mable around 9 p.m. She reminded Sally that visitation hours end at 7:30 p.m. and that Charles should be out of the building by then.

42 U.S.C. § 1396r(c)(3)

42 C.F.R. § 483.10(j)

Access and visitation rights.

(1) The resident has the right and the facility must provide immediate access to any resident by the following:

- (i) Any representative of the Secretary;
- (ii) Any representative of the State;
- (iii) The resident's individual physician;
- (iv) The State long term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965);
- (v) The agency responsible for the protection and advocacy system for developmentally disabled individuals (established under part C of the Developmental Disabilities Assistance and Bill of Rights Act);
- (vi) The agency responsible for the protection and advocacy system for mentally ill individuals (established under the Protection and Advocacy for Mentally Ill Individuals Act);
- (vii) Subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident; and
- (viii) Subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, others who are visiting with the consent of the resident.

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

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

Appendix PP, F172

Immediate family or other relatives are not subject to visiting hour limitations or other restrictions not imposed by the resident. Likewise, facilities must provide 24-hour access to other non-relative visitors who are visiting with the consent of the resident. These other visitors are subject to “reasonable restrictions” according to the regulatory language. “Reasonable

restrictions” are those imposed by the facility that protect the security of all the facility’s residents, such as keeping the facility locked at night; denying access or providing limited and supervised access to a visitor if that individual has been found to be abusing, exploiting, or coercing a resident; denying access to a visitor who has been found to have been committing criminal acts such as theft; or denying access to visitors who are inebriated and disruptive. The facility may change the location of visits to assist care giving or protect the privacy of other residents, if these visitation rights infringe upon the rights of other residents in the facility. For example, a resident’s family visits in the late evening, which prevents the resident’s roommate from sleeping.

An individual or representative of an agency that provides health, social, legal, or other services to the resident has the right of “reasonable access” to the resident, which means that the facility may establish guidelines regarding the circumstances of the visit, such as location. If there are problems with the facility’s provision of reasonable privacy for resident to meet with these representatives, refer to §483.10(e), Privacy and Confidentiality, Tag F164.

O.C.G.A. § 31-8-120

(a) Visitors must be granted access to residents, who have the right to refuse or terminate any visit. The facility must permit the resident’s representatives and representatives of any federally mandated ombudsman or advocacy program to have access to the resident. Access under this Code section shall be allowed during normal visitation hours.

(b) Each person entering a facility shall promptly disclose his presence and identity to the person in charge and shall enter the immediate living quarters of a resident only after identifying himself and receiving permission to enter. Such person shall leave immediately upon the resident’s request. The rights of other residents in the room and in the facility shall be respected.

(c) The administrator or person in charge of a facility may refuse access as described in this Code section or require a person to leave a facility only if he has reason to believe that the presence of the person seeking access would result in severe harm to any resident’s health, safety, or property; if the access is sought for financial solicitation or for commercial purposes; or if such access is refused by the resident.

(d) This Code section shall not limit the power of any public agency, ombudsman under Article 3 of this chapter, or other person permitted or required by law to enter and inspect a facility

Participation in Activities

42 U.S.C. § 1396r(c)(1)(A)(vii) and (viii)

A nursing facility must protect and promote the rights of each resident, including each of the following rights:

Participation in resident and family groups

The right of the resident to organize and participate in resident groups in the facility and the right of the resident's family to meet in the facility with the families of other residents in the facility.

Participation in other activities

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

42 C.F.R. § 483.15(c)

- (1) A resident has the right to organize and participate in resident groups in the facility;
- (2) A resident's family has the right to meet in the facility with the families of other residents in the facility;
- (3) The facility must provide a resident or family group, if one exists, with private space;
- (4) Staff or visitors may attend meetings at the group's invitation;
- (5) The facility must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings;
- (6) When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.

Appendix PP, F243 & F244

42 C.F.R. § 483.15(d)

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

Appendix PP, F245

O.C.G.A. § 31-8-121

The facility must permit the formation of a residents' council by interested residents, provide space for meetings, and provide assistance in attending meetings to those residents who require it. The facility may not compel attendance at or participation in residents' council meetings.

Restraints

42 U.S.C. § 1396r(c)(1)(A)(ii)

A nursing facility must protect and promote the rights of each resident, including each of the following rights:

The right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. Restraints may only be imposed—

- (I) to ensure the physical safety of the resident or other residents, and
- (II) only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances specified by the Secretary until such an order could reasonably be obtained).

42 U.S.C. § 1396r(c)(1)(D)

Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan (included in the written plan of care described in paragraph (2)) designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually an independent, external consultant reviews the appropriateness of the drug plan of each resident receiving such drugs.

42 C.F.R. § 483.13

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

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

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

(1) The facility must -

- (i) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;
- (ii) Not employ individuals who have been -
 - (A) Found guilty of abusing, neglecting, or mistreating residents by a court of law; or

- (B) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and
- (iii) Report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

(2) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

(3) The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

(4) The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

Appendix PP, F222 (Restraints)

Restraints may not be used for staff convenience. However, if the resident needs emergency care, restraints may be used for brief periods to permit medical treatment to proceed unless the facility has a notice indicating that the resident has previously made a valid refusal of the treatment in question. If a resident's unanticipated violent or aggressive behavior places him/her or others in imminent danger, the resident does not have the right to refuse the use of restraints. In this situation, the use of restraints is a measure of last resort to protect the safety of the resident or others and must not extend beyond the immediate episode. The facility may not use restraints in violation of the regulation solely based on a legal surrogate or representative's request or approval.

Finally, residents who are restrained may face a loss of autonomy, dignity and self-respect, and may show symptoms of withdrawal, depression, or reduced social contact.

Facility practices that meet the definition of a restraint include, but are not limited to:

- Using side rails that keep a resident from voluntarily getting out of bed;
- Tucking in or using Velcro to hold a sheet, fabric, or clothing tightly so that a resident's movement is restricted;

- Using devices in conjunction with a chair, such as trays, tables, bars or belts, that the resident cannot remove easily, that prevent the resident from rising;
- Placing a resident in a chair that prevents a resident from rising; and
- Placing a chair or bed so close to a wall that the wall prevents the resident from rising out of the chair or voluntarily getting out of bed.

Appendix PP, F223 (Abuse)

Appendix PP, F224 and F226 (Staff treatment of residents)

O.C.G.A. § 31-8-108(c)

Each resident shall be free from experimental research or treatment unless the informed, written consent of the resident or guardian is first obtained.

O.C.G.A. § 31-8-109

(a) Each resident shall be free from actual or threatened physical restraints, isolation, or restrictions on mobility within or outside the facility grounds, including the use of drugs to limit mobility, except to the minimum extent necessary to protect the resident from immediate injury to the resident or to others. In no event shall restraints, restrictions, or isolation be used for punishment, incentive, behavior conditioning or modification, or for the convenience of the facility.

(b) Restraints, restrictions, or isolation shall be used only subject to the following conditions:

(1) Prior to authorizing restraints, restrictions, or isolation, the attending physician shall make a personal examination and individualized determination of the need to use such restraints, restriction, or isolation on that resident and shall specify a reasonable time for such use. No restraint, restriction, or isolation shall be used by the facility longer than 65 days for intermediate care residents and longer than 35 days for skilled nursing residents, except by reorder of the attending physician after personal examination of the resident. Irrespective of such time period specified, restraints, restrictions, or isolation shall not be used beyond the period of actual need;

(2) In an emergency situation, restraints, restrictions, or isolation shall be authorized by the person in charge only to protect the resident from immediate injury to the resident or others and shall not be continued for more than 12 hours after the onset of the emergency without personal examination and authorization by the attending physician;

(3) The resident and a person designated by the resident, if any, shall be informed immediately of the need for the use of restraint, restriction, or isolation, the reasons for such use, and the time the physician has specified for such use. Such information shall be recorded in the resident's file;

(4) A restrained or isolated resident shall be monitored by the staff at least every hour and released and exercised at least every two hours, except during normal sleeping hours; and

(5) When a restraint, restriction, or isolation is used under this Code section, the resident shall retain all rights enumerated in this article.

Ga. R. & Regs. 111-8-56-.10

(9) Restraint and/or forcible seclusion of a patient will be used only on a signed order of a physician, except in emergency and then only until the advice of a physician can be obtained.

Privacy and Confidentiality

42 U.S.C. § 1396r(c)(1)(A)(iii) and (iv)

A nursing facility must protect and promote the rights of each resident, including each of the following rights:

The right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of resident groups.

The right to confidentiality of personal and clinical records and to access to current clinical records of the resident upon request by the resident or the resident's legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request.

42 C.F.R. § 483.10(e)

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

- (1) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident;
- (2) Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility;
- (3) The resident's right to refuse release of personal and clinical records does not apply when -
 - (i) The resident is transferred to another health care institution; or
 - (ii) Record release is required by law.

42 C.F.R. 483.10(k)

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

O.C.G.A. § 31-8-114

Each resident shall enjoy the right of privacy including, but not limited to, the following:

- (1) The right to privacy in the resident's room or the resident's portion of the room. The staff may not enter a resident's room without making their presence known, except when the resident is asleep, in an emergency threatening the health or safety of the resident, or as required by the resident's care plan;
- (2) The right to a private room and a personal sitter if the resident pays the difference between the facility's charge for such a room and sitter and the amount reimbursed

through Medicare or Medicaid;

(3) The right to private visits with the resident's spouse. Spouses shall be permitted to share a room when available where both are residents of the facility;

(4) The right to have unimpeded, private, and uncensored communication with anyone of the resident's choice by mail, public telephone, and visitation, provided that such visitation does not disturb other residents. The administrator shall provide that mail is received and mailed on regular postal delivery days, that telephones are accessible for confidential and private communications, and that at least one private place per facility is available for visits during normal visitation hours, which shall be for at least 12 continuous hours per day;

(5) The right to refuse acceptance of correspondence, telephone calls, or visitation by anyone;

(6) The right to respect and privacy in his medical, personal, and bodily care program. Each resident's case discussion, consultation, examination, treatment, and care shall be confidential and shall be conducted in privacy. Those persons not directly involved in the resident's care must have the resident's permission to be present; and

(7) The right to receive confidential treatment of the resident's personal and medical records. Only the resident or guardian may approve the release or disclosure of such records to any individual outside the facility, except in case of (A) the resident's transfer to another health care facility, (B) during a Medicare, Medicaid, licensure, medical care foundation, or peer review survey, or (C) as otherwise provided by law or third-party payment contract.

See Appendix PP, F164

Records

42 C.F.R. § 483.10(b)(2)

The resident or his or her legal representative has the right—

- (i) Upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays); and
- (ii) After receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and 2 working days advance notice to the facility.

Appendix PP, regarding 483.10(b)(2):

An oral request is sufficient to produce the current record for review.

In addition to clinical records, the term “records” includes all records pertaining to the resident, such as trust fund ledgers pertinent to the resident and contracts between the resident and the facility.

“Purchase” is defined as a charge to the resident for photocopying. If State statute has defined the “community standard” rate, facilities should follow that rate. In the absence of State statute, the “cost not to exceed the community standard” is that rate charged per copy by organizations such as the public library, the Post Office or a commercial copy center, which would be selected by a prudent buyer in addition to the cost of the clerical time needed to photocopy the records. Additional fees for locating the records or typing forms/envelopes may not be assessed.

Clinical records:

42 C.F.R. § 483.75(l)

- (1) The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are -
 - (i) Complete;
 - (ii) Accurately documented;
 - (iii) Readily accessible; and
 - (iv) Systematically organized.
- (2) Clinical records must be retained for -
 - (i) The period of time required by State law; or
 - (ii) Five years from the date of discharge when there is no requirement in State law; or
 - (iii) For a minor, three years after a resident reaches legal age under State law.
- (3) The facility must safeguard clinical record information against loss, destruction, or unauthorized use;

(4) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is required by -

- (i) Transfer to another health care institution;
- (ii) Law;
- (iii) Third party payment contract; or
- (iv) The resident.

(5) The clinical record must contain -

- (i) Sufficient information to identify the resident;
- (ii) A record of the resident's assessments;
- (iii) The plan of care and services provided;
- (iv) The results of any preadmission screening conducted by the State; and
- (v) Progress notes.

O.C.G.A. § 31-8-106(e)

Each resident or guardian shall be permitted to inspect and receive a copy of the resident's nonmedical records kept by the facility. The facility may charge a reasonable fee for duplication, which fee shall not exceed actual cost.

Ga. R. & Regs. 111-8-56-.10

(4) Reports of all evaluations and examinations shall be kept with the patient's medical records.

Ga. R. & Regs. 111-8-56-.11

(1) Each home shall maintain a complete medical record on each patient containing sufficient information to validate the diagnosis and to establish the basis upon which treatment is given. All active medical records shall be maintained at the nurses' station. The completed record shall normally contain the following:

- (a) Name, address, birth date, sex, marital status of the patient and religion; the name, address and telephone number of physician; the name, address and telephone number of the responsible party to contact in emergency;
- (b) Date and time of admission;
- (c) Date and time of discharge or death;
- (d) Admitting diagnosis;
- (e) Final diagnosis;
- (f) Condition on discharge;
- (g) History and physical examination;
- (h) Treatment and medication orders;
- (i) Physicians' progress notes (at least monthly);
- (j) Nurses' notes;
- (k) Special examination and reports.

(2) Each home shall keep patient statistics, including admissions, discharges, deaths, patient days, and percent of occupancy. Statistical records shall be open for inspection and upon request, data shall be submitted to the Department.

Equal Access to Care

42 U.S.C. § 1396r(c)(4)(A)

A nursing facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services required under the State plan for all individuals regardless of source of payment.

42 C.F.R. § 483.12(c)

- (1) A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all individuals regardless of source of payment;
- (2) The facility may charge any amount for services furnished to non-Medicaid residents consistent with the notice requirement in § 483.10(b)(5)(i) and (b)(6) describing the charges; and
- (3) The State is not required to offer additional services on behalf of a resident other than services provided in the State plan.

Appendix PP, F207

Facilities must treat all residents alike when making transfer and discharge decisions. "Identical policies and practices" concerning services means that facilities must not distinguish between residents based on their source of payment when providing services that are required to be provided under the law. All nursing services, specialized rehabilitative services, social services, dietary services, pharmaceutical services, or activities that are mandated by the law must be provided to residents according to residents' individual needs, as determined by assessments and care plans.

Control Over and Use of Funds

O.C.G.A. § 31-8-115(a) – (b)(5)

(a) Any payments made to or on behalf of a resident, regardless of the payee, shall be used exclusively for the resident's benefit, unless otherwise required by law.

(b) Each resident or his guardian shall be permitted to manage the financial affairs of the resident and to withdraw and use funds from any personal account established for him at the facility. The resident or his guardian may authorize the administrator or other person employed by the facility to assist in the management of such resident's financial affairs, either wholly or partially, subject to the following conditions:

(1) Such authorization must be in writing and maintained in the resident's files;

(2) Resident's funds shall be expended by the facility only with prior written consent or upon the immediate request of the resident or guardian;

(3) The resident, his guardian, or representative shall be given any portion or all of the resident's funds upon the request of the resident or guardian;

(4) A current written record of all financial arrangements and transactions involving the resident's funds shall be maintained and made available to the resident or guardian for inspection and copying upon request. A written statement showing the current balance and an itemized listing of all transactions shall be provided to each resident or guardian at least quarterly and prior to any change in ownership of the facility;

(5) Funds received from a resident or on his behalf may be deposited in an interest-bearing account, but in any event all funds not needed for ordinary use by residents on a daily basis shall be deposited in an account insured by agencies of or corporations chartered by the state or federal government and in a form which clearly indicates that the facility has only a fiduciary interest in the funds. Any interest earned on such account shall accrue to the resident; and

Transfers and Discharge

42 U.S.C. § 1396r(c)(2).

42 CFR 483.12(a)(2)

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

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

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

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

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

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

(vi) The facility ceases to operate.

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

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

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

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

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

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

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

(5) Timing of the notice.

(i) Except as specified in paragraphs (a)(5)(ii) and (a)(8) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.

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

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

- (B)** The health of individuals in the facility would be endangered, under paragraph (a)(2)(iv) of this section;
- (C)** The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(ii) of this section;
- (D)** An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(i) of this section; or
- (E)** A resident has not resided in the facility for 30 days.

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

- (i)** The reason for transfer or discharge;
- (ii)** The effective date of transfer or discharge;
- (iii)** The location to which the resident is transferred or discharged;
- (iv)** A statement that the resident has the right to appeal the action to the State;
- (v)** The name, address and telephone number of the State long term care ombudsman;
- (vi)** For nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and
- (vii)** For nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.

Generally, Appendix PP, F177, F201 through F204

Appendix PP, F177

A resident cannot be transferred for non-payment if he or she has submitted to a third party payor all the paperwork necessary for the bill to be paid. Non-payment would occur if a third party payor, including Medicare or Medicaid, denies the claim and the resident refused to pay for his or her stay.

Appendix PP, F202

Conversion from a private pay rate to payment at the Medicaid rate does not constitute non-payment.

If a nursing home discharges a resident or retaliates due to an existing resident's failure to sign or comply with a binding arbitration agreement, the State and Region may initiate an enforcement action based on a violation of the rules governing resident discharge and transfer. A current resident is not obligated to sign a new admission agreement that contains binding arbitration.

Discharge Summaries

42 C.F.R. § 483.20(l)

When the facility anticipates discharge a resident must have a discharge summary that includes -

- (1) A recapitulation of the resident's stay;
- (2) A final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative; and
- (3) A post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.

O.C.G.A. § 31-8-116

(a) Except in an emergency, where the resident or other residents are subject to an imminent and substantial danger that only immediate transfer or discharge will relieve or reduce, a facility may involuntarily transfer a resident only in the following situations **and after other reasonable alternatives to transfer have been exhausted:**

(1) A physician determines that failure to transfer the resident will threaten the health or safety of the resident or others and documents that determination in the resident's medical record. If the physician determines that the facility cannot provide care, treatment, and services which are adequate and appropriate, it shall be conclusively presumed that the failure to transfer will threaten the health or safety of the resident. If the basis for the transfer or discharge is the safety of the resident himself, the resident shall not be involuntarily transferred or discharged unless a physician determines that such transfer or discharge is not reasonably expected to endanger the resident to a greater extent than remaining in the facility and documents that determination in the resident's medical records;

(2) The facility does not participate in or voluntarily or involuntarily ceases to operate or participate in the program which reimburses the cost of the resident's care;

(3) Nonpayment of allowable fees has occurred. **The conversion of a resident from private pay status to Medicaid eligibility due to exhaustion of personal financial resources or from Medicare to Medicaid does not constitute nonpayment of fees under this paragraph;** or

(4) When the findings of a Medicare or Medicaid medical necessity review determine that the resident no longer requires the level of care provided at the facility.

(b) If the facility voluntarily or involuntarily ceases to operate or participate in the program which reimburses the costs of the resident's care, the facility must cooperate fully with the state Medicaid agency and the Centers for Medicare and Medicaid Services regional office in the implementation of any transfer planning and transfer counseling conducted by these agencies.

(c) The facility shall assist the resident and guardian in finding a reasonably appropriate alternative placement prior to the proposed transfer or discharge. The plan for such transfer or discharge shall be designed to mitigate the effects of transfer stress to the resident. Such plan shall include counseling the resident, guardian, or representative

regarding available community resources and informing the appropriate state or social service organization.

(d) The facility must notify the resident, guardian or representative, and attending physician at least 30 days before any involuntary transfer, except a transfer pursuant to paragraph (4) of subsection (a) of this Code section. This notice must be in writing and must contain:

- (1) The reasons for the proposed transfer;
- (2) The effective date of the proposed transfer;
- (3) Notice of the right to a hearing pursuant to Code Section 31-8-125 and of the right to representation by legal counsel; and

- (4) The location to which the facility proposes to transfer the resident.

(e) The resident shall receive at least 15 days' notice prior to an involuntary intrafacility transfer.

(f) If two residents in a facility are married and the facility proposes to transfer involuntarily one spouse to another facility at a similar level of care, the facility must give the other spouse notice of his or her right to be transferred to the same facility. If the spouse notifies a facility in writing that he wishes to be transferred, the facility must transfer both spouses on the same day, pending availability of accommodations.

(g) Each resident shall be discharged from a facility after the resident or guardian gives the administrator or person in charge of the facility notice of the resident's desire to be discharged and the date of the expected departure. Where the resident appears to be incapable of living independently of the facility, the facility shall notify the Department of Human Services in order to obtain social or protective assistance for the resident immediately. The notice of the discharge by the resident or guardian, the expected and actual date thereof, and notice to the department, where required, shall be documented in the resident's records. Upon such discharge and, if required, notice to the department, the facility is relieved from any further responsibility for the resident's care, safety, or well-being.

(h) Whenever allowed by the resident's health condition, a resident shall be provided treatment and care, rehabilitative services, and assistance by the facility to prepare the resident to return to the resident's home or other living situation less restrictive than the facility. Upon the request of the resident, guardian, or representative, the facility shall provide him with information regarding available resources and inform him of the appropriate state or social service organizations.

(i) Each resident transferred from a facility to a hospital, other health care facility, or trial alternative living placement shall have the right to return to the facility immediately upon discharge from the hospital or other health care facility or upon termination of the trial living placement, provided that the resident has continued to pay the facility or third-party payment is provided for the period of the resident's absence. In cases of nonpayment to the facility during such absence, a resident who requests to return to a facility from a hospital shall be admitted by the facility to the first bed available after discharge from the hospital.

42 C.F.R. § 483.204 provides that each State must provide a system for appealing a notice of discharge or transfer.

See Nursing home to pay \$3.5 million to settle illegal patient transfer allegations, at <http://www.mcknights.com/news/nursing-home-to-pay-35-million-to-settle-illegal-patient-transfer-allegations/article/522043/>

Grievances

<p>Mable also mentions that her roommate, who appears to have dementia, has been taking her stuff and wearing her clothes.</p>
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42 U.S.C. § 1396r(c)(1)(A)(vi)

A nursing facility must protect and promote the rights of each resident, including each of the following rights:

The right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances and the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

42 C.F.R. § 483.10(f)

A resident has the right to -

- (1) Voice grievances without discrimination or reprisal. Such grievances include those with respect to treatment which has been furnished as well as that which has not been furnished; and
- (2) Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

Appendix PP, F166

O.C.G.A. § 31-8-118(c)

Each resident shall be permitted to voice complaints and recommend changes in policies, procedures, and services to the administrator, his designee, or the residents' council.

O.C.G.A. § 31-8-123

Every effort shall be made to use the state ombudsman or community ombudsman, as provided for in Article 3 of this chapter, to resolve complaints related to residents' rights.

O.C.G.A. § 31-8-124

(a) Any resident, guardian, or representative who believes his rights under this article have been violated by a facility shall be permitted to file a grievance under this Code section.

(b) To initiate the grievance, the resident, guardian, or representative may submit an

oral or written complaint to the administrator or his designee. The administrator or his designee shall act to resolve the complaint or shall respond to the complaint within three business days, including in the response a description of the review and appeal rights set forth in this Code section.

(c) If the person filing the complaint is not satisfied by the action taken by the administrator or his designee, the complainant shall submit an oral or written complaint to the state or community ombudsman, pursuant to Article 3 of this chapter.

(d) If the ombudsman does not resolve the grievance to the complainant's satisfaction within ten days, the complainant may submit the grievance to an impartial referee, jointly chosen by the administrator or his designee and the complainant, who will conduct a hearing.

(e) The referee's hearing shall be held at the facility within 14 days after submission of the grievance to him, at a time convenient to the referee, the complainant, and the administrator. The complainant and the administrator may review relevant records and documents, present evidence, call witnesses, cross-examine witnesses, make oral arguments, and be represented by any person of their choice. The referee may ask questions of any person, review relevant records and documents, call witnesses, and receive other evidence as appropriate. The referee shall keep a record of the proceedings, which record may be a sound recording. Within 72 hours after the grievance review, the referee shall render a decision and shall give to the complainant and to the administrator a written statement of the decision and reasons therefor, which statement shall also describe the appeal rights set forth in Code Section 31-8-125. Such decision shall be binding on the parties unless reversed upon appeal.

(f) The facility shall maintain a central file of documents pertaining to grievances, such file to be confidential, except that any resident, guardian, or representative may review any document pertaining to the resident and all documents shall be available to the department for inspection. This subsection shall not apply to any documents protected by the attorney-client privilege.

(g) If a resident or complainant is unable for any reason to understand any writing or communication pertinent to this Code section, such information shall be communicated to him in a manner that takes into account any communication impairment he may have.

(h) A resident, guardian, or representative who elects not to proceed under this Code section shall not be prohibited from proceeding under Code Section 31-8-125 or 31-8-126.

Administrative hearings:

O.C.G.A. § 31-8-125

(a) Any resident, guardian, or representative who believes his rights under Code Section 31-8-107, paragraph (3) of subsection (b) of Code Section 31-8-108, Code Section 31-8-109, paragraphs (3) and (4) of Code Section 31-8-111, subsection (d) of Code Section 31-8-112, Code Section 31-8-116, Code Section 31-8-117, or Code Section 31-8-120 have been violated or any complainant or facility dissatisfied with a decision of a referee shall have the right to request a hearing from the department pursuant to Chapter 13 of Title

50, the "Georgia Administrative Procedure Act." The department is authorized to hold such hearings and, in the case of an appeal of a decision of a referee, the department may hold such hearings by review of the record.

(b) The hearing shall be conducted within 45 days of the receipt by the department of the request for a hearing. Except where the state or community ombudsman has already been involved in the matter at issue, the department may refer the complaint to the state or community ombudsman for informal resolution pending the hearing.

(c) Except in the event of an emergency situation in which the resident or other residents are subject to imminent and substantial danger that only immediate transfer will relieve or reduce or except in case of nonpayment, no transfer shall take place until all appeal rights are exhausted.

(d) The department shall hold such hearings at the facility upon the resident's request or as necessary due to the resident's medical condition. Where residents of a facility allege a common complaint, the department may at the residents' request schedule a single hearing.

(e) If the department finds no violations of this article, the resident and facility will be so informed. If a violation has occurred, the department shall order the facility to correct such violation; and, upon failure to correct such violation within a reasonable time, the department may impose appropriate civil penalties as provided for in Code Section 31-8-126.

Assessment

Basic Rule: 42 U.S.C. § 1396r(b)(3)(A)

A nursing facility must conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity, which assessment—

- (i) describes the resident's capability to perform daily life functions and significant impairments in functional capacity;
- (ii) is based on a uniform minimum data set specified by the Secretary under subsection (f)(6)(A) of this section;
- (iii) uses an instrument which is specified by the State under subsection (e)(5) of this section; and
- (iv) includes the identification of medical problems.

Certification: Each assessment must be certified by a registered professional nursing, and each person who completes a portion of the assessment shall sign and certify its accuracy. 42 U.S.C. § 1396r(b)(3)(B); 42 C.F.R. § 483.20(i).

Frequency:

42 U.S.C. § 1396r(b)(3)(C)(i)

Such an assessment must be conducted—

- (I) promptly upon (but no later than 14 days after the date of) admission for each individual admitted on or after October 1, 1990, and by not later than October 1, 1991, for each resident of the facility on that date;
- (II) promptly after a significant change in the resident's physical or mental condition; and
- (III) in no case less often than once every 12 months.

See also 42 C.F.R. § 483.20(b)(2).

Review every 3 months: The nursing facility must examine each resident no less frequently than once every 3 months and, as appropriate, revise the resident's assessment to assure the continuing accuracy of the assessment. 42 U.S.C. § 1396r(b)(3)(C)(ii); 42 C.F.R. § 483.20(c).

Use: The results of such an assessment shall be used in developing, reviewing, and revising the resident's plan of care under paragraph (2). 42 U.S.C. § 1396r(b)(3)(D); 42 C.F.R. § 483.20(d).

On Admission: At the time each resident is admitted, the facility must have physician orders for the resident's immediate care. 42 C.F.R. § 483.20(a).

Appendix PP, F271

Comprehensive nature of assessment: A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: (i) Identification and demographic information; (ii) Customary routine; (iii) Cognitive patterns; (iv) Communication; (v) Vision; (vi) Mood and behavior patterns; (vii) Psychosocial well-being; (viii) Physical functioning and structural problems; (ix) Continence; (x) Disease diagnoses and health conditions; (xi) Dental and nutritional status; (xii) Skin condition. (xiii) Activity pursuit; (xiv) Medications; (xv) Special treatments and procedures. (xvi) Discharge potential; (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. 42 C.F.R. § 483.20(b)(1).

Appendix PP, F272 through 276, F286

Accuracy: The assessment must accurately reflect the resident's status. 42 C.F.R. § 483.20(g).

Appendix PP, F278

Written Care Plan

A few days after Mable is admitted, the care plan coordinator calls Sally to let her know they are going to schedule a care plan meeting. She explains that this is where they inform Sally what kind of care Mable will receive.

See Free Choice – 42 C.F.R. § 483.10(d)

See Right to Dignified Existence - 42 C.F.R. § 483.15(b)

42 U.S.C. § 1396r(b)(2)

A nursing facility must provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a **written plan of care** which—

(A) describes the medical, nursing, and psychosocial needs of the resident and how such needs will be met;

(B) is initially prepared, with the participation to the extent practicable of the resident or the resident's family or legal representative, by a team which includes the resident's attending physician and a registered professional nurse with responsibility for the resident; and

(C) is periodically reviewed and revised by such team after each assessment under paragraph (3).

42 C.F.R. § 483.20(k)

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

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

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

(2) A comprehensive care plan must be -

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

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

- (iii) Periodically reviewed and revised by a team of qualified persons after each assessment.
- (3) The services provided or arranged by the facility must -
- (i) Meet professional standards of quality; and
 - (ii) Be provided by qualified persons in accordance with each resident's written plan of care.

Appendix PP, F279

Appendix PP, F280 (Resident's right to participate in care plan)

Appendix PP, F281 (Professional Standards)

The intent of this regulation is to assure that services being provided meet professional standards of quality (in accordance with the definition provided below) and are provided by appropriate qualified persons (e.g., licensed, certified).

“Professional standards of quality” means services that are provided according to accepted standards of clinical practice. Standards may apply to care provided by a particular clinical discipline or in a specific clinical situation or setting. Standards regarding quality care practices may be published by a professional organization, licensing board, accreditation body or other regulatory agency. Recommended practices to achieve desired resident outcomes may also be found in clinical literature. Possible reference sources for standards of practice include:

- Current manuals or textbooks on nursing, social work, physical therapy, etc.
- Standards published by professional organizations such as the American Dietetic Association, American Medical Association, American Medical Directors Association, American Nurses Association, National Association of Activity Professionals, National Association of Social Work, etc.
- Clinical practice guidelines published by the Agency of Health Care Policy and Research.
- Current professional journal articles.

If a negative resident outcome is determined to be related to the facility's failure to meet professional standards, and the team determines a deficiency has occurred, it should be cited under the appropriate quality of care or other relevant requirement.

O.C.G.A. § 31-8-108(b)(2)

In the provision of care, treatment, and services to the resident by the facility, each resident or guardian shall be entitled to the following: (2) To participate in the overall

planning of the resident's care and treatment. The resident or guardian shall be informed of this right each time a substantial change in the treatment plan is made.

Ga. R. & Regs. 111-8-56-.10

- (1) Each patient shall have a physician's written statement of his or her condition at time of admission or within forty-eight (48) hours thereafter and it shall be kept on file with the patient's medical record.
- (2) Each patient shall have a physician's orders for treatment and/or care upon admission to the facility.
- (3) Each home shall have an adequate arrangement for medical and dental emergencies.

Care

A news article dated September 7, 2016, reports that the U.S. Attorney's office filed suit against Vanguard HealthCare for failing to take care of elderly patients at six homes. "[F]ederal prosecutors allege the nursing homes failed to provide basic care. They say the facilities had chronic staffing shortages and shortages of critical medical supplies and failed to provide skilled nursing services, failed to manage patients' pain, failed to prevent falls, and failed to provide wound care. They also used unnecessary restraints and gave patients too much, too little and sometimes the wrong medication." See J. Kraus, *U.S. Attorney: Nursing Home Operator Provided "Non-Existent" Care*, at <http://www.newschannel5.com/news/newschannel-5-investigates/us-attorney-nursing-home-operator-provided-non-existent-care>.

42 C.F.R. § 483.25

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

Appendix PP, F309

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

NOTE: Use guidance at F309 for review of quality of care not specifically covered by 42 CFR 483.25 (a)-(m). Tag F309 includes, but is not limited to, care such as care of a resident with dementia, end-of-life, diabetes, renal disease, fractures, congestive heart failure, non-pressure related skin ulcers, pain, and fecal impaction.

Definitions: §483.25

"Highest practicable physical, mental, and psychosocial well-being" is defined as the highest possible level of functioning and well-being, limited by the individual's recognized pathology and normal aging process. Highest practicable is determined through the comprehensive resident assessment and by recognizing and competently and thoroughly addressing the physical, mental or psychosocial needs of the individual.

Harm	
a. Actual - Was there an outcome of harm? Does the harm meet the definition of Immediate Jeopardy, e.g., has the provider's noncompliance caused serious	Yes. Repeated, extreme reaction to attempts to bathe with visible anguish, crying and yelling out reflects actual psychological harm

injury, harm, impairment, or death to an individual?	with no attempts to alter the care plan.
b. Potential – Is there a likelihood of potential harm? Does the potential harm meet the definition of Immediate Jeopardy; e.g., is the provider’s noncompliance likely to cause serious injury, harm, impairment, or death to an individual?	Yes. Repeated risk of a serious fall on an already injured or vulnerable area due to the struggle related to attempted showering.
Immediacy	
Is the harm or potential harm likely to occur in the very near future to this individual or others in the entity, if immediate action is not taken?	Yes. Potential for subsequent harm (a fall or other injury, psychological harm) exists as the facility did not attempt to identify causes or modify alternate interventions related to showers. Other residents with dementia may also be at risk, as staff had not received training in caring for individuals with dementia including how to understand the communication efforts of residents with dementia. There was no evidence of physician participation with the QA&A committee.
Culpability	
Did the facility know about the situation? If so when did the facility first become aware?	Yes, it had happened repeatedly and the social worker and nurses had been informed on admission of the resident’s fear and preferences. While the information was in the care plan, the team had not passed the information along to the direct care staff and staff did not review the care plan. Staff did not intervene during these episodes despite the resident’s cries for help. These behaviors were attributed to her dementia and were not considered remediable.
Should the facility have known about the situation?	Yes. There were recurrent episodes and the family had reported similar behavior at home related to showers.

42 C.F.R. § 483.25(a)

Based on the comprehensive assessment of a resident, the facility must ensure that—

- (1) A resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to—
 - (i) Bathe, dress, and groom;
 - (ii) Transfer and ambulate;
 - (iii) Toilet;
 - (iv) Eat; and
 - (v) Use speech, language, or other functional communication systems.
- (2) A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section; and
- (3) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

Appendix PP, F310 through F312

O.C.G.A. § 31-8-108(a)

(a) Each resident shall receive care, treatment, and services which are adequate and appropriate. Care, treatment, and services shall be provided as follows:

- (1) With reasonable care and skill;
- (2) In compliance with applicable laws and regulations;
- (3) Without discrimination in the quality of a service based on the source of payment for the service;
- (4) With respect for the resident's personal dignity and privacy; and
- (5) With the goal of the resident's return home or to another environment less restrictive than the facility.

Ga. R. & Regs. 111-8-56-.10

(8) Nursing care shall be provided each patient according to his needs and in accordance with his patient care plan.

Standards of Care:

<https://guideline.gov/>

Services That Must Be Provided

42 U.S.C. § 1396r(b)(4)

To the extent needed to fulfill all plans of care described in paragraph (2), a nursing facility must provide (or arrange for the provision of)—

- (i) **nursing and related services and specialized rehabilitative services** to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident;
- (ii) **medically-related social services** to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident;
- (iii) **pharmaceutical services** (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident;
- (iv) **dietary services** that assure that the meals meet the daily nutritional and special dietary needs of each resident;
- (v) **an on-going program**, directed by a qualified professional, **of activities** designed to meet the interests and the physical, mental, and psychosocial well-being of each resident;
- (vi) **routine dental services** (to the extent covered under the State plan) and emergency dental services to meet the needs of each resident; and
- (vii) **treatment and services required by mentally ill and mentally retarded residents** not otherwise provided or arranged for (or required to be provided or arranged for) by the State.

The services provided or arranged by the facility must meet professional standards of quality.

Physician Services

42 C.F.R. § 483.40

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

- (a) Physician supervision. The facility must ensure that -
 - (1) The medical care of each resident is supervised by a physician; and
 - (2) Another physician supervises the medical care of residents when their attending physician is unavailable.
- (b) Physician visits. The physician must -
 - (1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section;
 - (2) Write, sign, and date progress notes at each visit; and
 - (3) Sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.
- (c) Frequency of physician visits.
 - (1) The resident must be seen by a physician **at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.**
 - (2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.
 - (3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally.
 - (4) At the option of the physician, required visits in SNFs after the initial visit may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner, or clinical nurse specialist in accordance with paragraph (e) of this section.
- (d) Availability of physicians for emergency care. The facility must provide or arrange for the provision of physician services 24 hours a day, in case of an emergency.
- (e) Physician delegation of tasks in SNFs.
 - (1) Except as specified in paragraph (e)(2) of this section, a physician may delegate tasks to a physician assistant, nurse practitioner, or clinical nurse specialist who -
 - (i) Meets the applicable definition in § 491.2 of this chapter or, in the case of a clinical nurse specialist, is licensed as such by the State;
 - (ii) Is acting within the scope of practice as defined by State law; and
 - (iii) Is under the supervision of the physician.
 - (2) A physician may not delegate a task when the regulations specify that the physician must perform it personally, or when the delegation is prohibited under State law or by the facility's own policies.

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

42 C.F.R. § 483.10(b)(9)

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

Appendix PP, F156

“Physician responsible for his or her care” is defined as the attending or primary physician or clinic, whichever is responsible for managing the resident’s medical care, and excludes other physicians whom the resident may see from time to time. When a resident has selected an attending physician, it is appropriate for the facility to confirm that choice when complying with this requirement. When a resident has no attending physician, it is appropriate for the facility to assist residents to obtain one in consultation with the resident and subject to the resident’s right to choose. (See §483.10(d)(1), F163.)

Medical director:

42 C.F.R. § 483.75(i)

- (1) The facility must designate a physician to serve as medical director.
- (2) The medical director is responsible for -
 - (i) Implementation of resident care policies; and
 - (ii) The coordination of medical care in the facility.

Ga. R. & Regs. § 111-8-56-.05

(1) There shall be an organized professional staff, with one physician designated as chief of staff. The professional staff shall consist of at least one physician, one dentist and one registered nurse. Other professional personnel such as the dietitian, social worker, physical therapist, pharmacist, etc. may be included on the professional staff. This organization shall function under appropriate bylaws and shall meet at regularly scheduled intervals not less than semiannually. It shall be the responsibility of this staff to develop and review care policies and to advise administration on matters pertaining to patient care. The minutes of the meetings of this staff shall be available for inspection by the Department.

(2) Patients shall be admitted only on referral of a physician.

(3) Each patient shall be under the continuing care of a physician who sees the patient at least once every thirty (30) days following admission. The patient’s total program of care (including medications and treatment) is reviewed during a visit by the attending physician at least once every thirty (30) days for the first ninety (90) days, and revised as necessary. A progress note is written and signed by the physician at the time of each

visit and he signs all his orders. Subsequent to the ninetieth day following admission, an alternate schedule for physician visits may be adopted where the attending physician determines and so justifies in the patient's medical record that the patient's condition does not necessitate visits at thirty-day intervals.

Administration

42 C.F.R. § 483.75

A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

Governing body:

42 C.F.R. § 483.75(d)

- (1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and
- (2) The governing body appoints the administrator who is -
 - (i) Licensed by the State where licensing is required; and
 - (ii) Responsible for management of the facility.

Disclosure of ownership:

42 C.F.R. § 483.75(p)

- (1) The facility must comply with the disclosure requirements of §§ 420.206 and 455.104 of this chapter.
- (2) The facility must provide written notice to the State agency responsible for licensing the facility at the time of change, if a change occurs in -
 - (i) Persons with an ownership or control interest, as defined in §§ 420.201 and 455.101 of this chapter;
 - (ii) The officers, directors, agents, or managing employees;
 - (iii) The corporation, association, or other company responsible for the management of the facility; or
 - (iv) The facility's administrator or director of nursing.
- (3) The notice specified in paragraph (p)(2) of this section must include the identity of each new individual or company.

Ga. R. & Regs. § 111-8-56-.02

- (1) There shall be a governing body which assumes full legal responsibility for the overall conduct of the home.
- (2) The ownership of the home shall be fully disclosed to the Department. In the case of corporations, partnerships and other bodies created by statute the corporate officers and all others owning ten percent or more of the corporate stock or ownership shall be made known to the Department.
- (3) The governing body shall be responsible for compliance with all applicable laws and regulations pertaining to the home.
- (4) The governing body shall certify to the Commissioner, the name of the person to whom is delegated the responsibility for the management of the home, including the

carrying out of rules and policies adopted by the governing body. This person shall be known as the administrator.

(5) The word hospital, sanitorium or sanitarium shall not be used in the official title of any home permitted under the provisions of these rules and regulations.

Ga. R. & Regs. § 111-8-56-.03

(1) Each nursing home shall be under the supervision of a licensed nursing home administrator. An administrator may serve as the administrator of not more than one facility, except that two facilities having common ownership or management located on the same premises may be served by a single administrator. Distinct part facilities sharing a common roof shall be considered one facility. In exceptional circumstances, a waiver may be granted by the Department for a period of six months. Existing facilities not currently meeting this requirement would be exempt for a period of two years from the effective date of this regulation. If an existing facility should undergo a change of administrators during this two-year period, such facility would be required to comply with the regulations.

(2) Each home shall be operated in accordance with policies approved by the Department. These policies shall include but not be limited to those governing admissions, transfers, discharges, physicians' services, nursing services, dietary services, restorative services, pharmaceutical services, diagnostic services, social services, environmental sanitation services, recreational services and clinical records.

(3) Each home shall have a written transfer agreement in effect with one or more hospitals. Nursing homes that are a Distinct Part of a hospital will be considered to meet this requirement if acceptable provisions for the transfer of patients are included in the facility's policies.

(4) There shall be a separate personnel folder maintained for each employee. This folder shall contain all personal information concerning the employee, including the application and qualifications for employment, physical examination and job title assigned. A current job description shall be available for each classification of employee, but may be maintained separately from the personnel folder. In addition to all other documents required by state or federal regulations, the nursing home shall maintain documentation of successful completion of the dining assistant training program for each dining assistant.

(5) The home and its premises shall be used only for the purposes for which the home is operated and permitted.

(6) In response to a reasonable request by a patient or visitor, privacy shall be afforded for conversation and/or consultations.

Staffing

Nursing services:

42 U.S.C. § 1396r(b)(4)(C)(i)

With respect to nursing facility services provided on or after October 1, 1990, a nursing facility—

- (I) except as provided in clause (ii), must provide 24-hour licensed nursing services which are sufficient to meet the nursing needs of its residents, and
- (II) except as provided in clause (ii), must use the services of a registered professional nurse for at least 8 consecutive hours a day, 7 days a week.

Sufficient staff:

42 C.F.R. § 483.30(a)

- (1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:
 - (i) Except when waived under paragraph (c) of this section, licensed nurses; and
 - (ii) Other nursing personnel.
- (2) Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

Registered nurse:

42 C.F.R. § 483.30(b)

- (1) Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.
- (2) Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.
- (3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.

Ga. R. & Regs. § 111-8-56-.04

- (1) **A registered nurse shall be employed full time as director of nursing services.** She shall not also be the administrator.
- (2) The director of nursing services shall normally be employed on the daytime shift and shall devote full time to the administration of the nursing service which includes a reasonable amount of time with all nursing shifts.
- (3) The director of nursing services may also serve as the director of nursing services in another facility in close proximity to the home provided she has a registered nurse assistant who is assigned to each facility full time as supervisor of nursing care. The director's assistant shall devote full time to the supervision of nursing care.

(4) There shall be at least one nurse, registered, licensed undergraduate, or licensed practical on duty and in charge of all nursing activities during each eight-hour shift.

(5) There shall be sufficient nursing staff on duty at all times to provide care for each patient according to his needs. A minimum of 2.0 hours of direct nursing care per patient in a 24-hour period must be provided. For every seven (7) total nursing personnel required, there shall be not less than one registered nurse or licensed practical nurse employed. Dining assistants are to be used to supplement, not replace, existing nursing staff requirements and as such are not considered nursing staff and are not to be included in computing the required minimum hours of direct nursing care.

(6) The nursing staff shall be employed for nursing duties only.

(7) There shall be sufficient qualified personnel in attendance at all times to ensure properly supervised nursing services to the patients, including direct supervision of dining assistants in accordance with these rules. This includes staff members dressed, awake and on duty all night.

(8) All nursing care and related services shall be carried out in accordance with the facility's patient care policies. The lines of administrative authority and supervisory responsibility shall be clearly stated. Duties assigned to staff members shall be clearly defined and consistent with their training and experience. Policies and procedures governing nursing care shall be assembled, available and understood by the staff members and shall be the basis for staff education and practice.

(9) An active in-service nursing education program shall be in effect for all nursing personnel. This program shall be developed and conducted by a registered nurse who may be employed part-time and under the direction of the director of nursing services.

(10) The in-service nursing educational program shall be in writing and shall show the frequency of training. Attendance and progress records shall be kept for each person receiving instruction.

Nurse aides:

42 C.F.R. § 483.75(e) and (f)

(e) Required training of nursing aides -

(1) Definitions.

Licensed health professional means a physician; physician assistant; nurse practitioner; physical, speech, or occupational therapist; physical or occupational therapy assistant; registered professional nurse; licensed practical nurse; or licensed or certified social worker.

Nurse aide means any individual providing nursing or nursing-related services to residents in a facility who is not a licensed health professional, a registered dietitian, or someone who volunteers to provide such services without pay. Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants as defined in § 488.301 of this chapter.

(2) General rule. A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless:

-
- (i) That individual is competent to provide nursing and nursing related services; and
 - (ii)
 - (A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §§ 483.151-483.154 of this part; or
 - (B) That individual has been deemed or determined competent as provided in § 483.150 (a) and (b).
 - (3) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (e)(2) (i) and (ii) of this section.
 - (4) Competency. A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual -
 - (i) Is a full-time employee in a State-approved training and competency evaluation program;
 - (ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or
 - (iii) Has been deemed or determined competent as provided in § 483.150 (a) and (b).
 - (5) Registry verification. Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless -
 - (i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or
 - (ii) The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.
 - (6) Multi-State registry verification. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual.
 - (7) Required retraining. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.
 - (8) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide

regular in-service education based on the outcome of these reviews. The in-service training must -

- (i) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year;
 - (ii) Address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and
 - (iii) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.
- (f) Proficiency of Nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

Other staff:

42 C.F.R. § 483.75(g)

- (1) The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements.
- (2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws.

Activities

42 C.F.R. § 483.15(f)

- (1) The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.
- (2) The activities program must be directed by a qualified professional who -
 - (i) Is a qualified therapeutic recreation specialist or an activities professional who -
 - (A) Is licensed or registered, if applicable, by the State in which practicing; and
 - (B) Is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or
 - (ii) Has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or
 - (iii) Is a qualified occupational therapist or occupational therapy assistant; or
 - (iv) Has completed a training course approved by the State.

Ga. R. & Regs. § 111-8-56-.16

- (1) An individual shall be designated as being in charge of patient activities. This individual shall have experience and/or training in group activities, or shall have consultation made available from a qualified recreational therapist or group activity leader.
- (2) Provisions shall be made for suitable recreational and entertainment activities for patients according to their needs and interests. These activities are an important adjunct to daily living and are to encourage restoration to self-care and resumption of normal activities. Variety in planning shall include some outdoor activities in suitable weather.
- (3) Patients shall be encouraged but not forced to participate in patient activities.
- (4) The facility shall make available a variety of supplies and equipment adequate to satisfy the individual interests of residents. Examples are: books, magazines, daily newspapers, games, stationery, radio, television and the like.
- (5) An active patient activities program shall be carried out that will meet the needs of all patients.

Social Services

42 C.F.R. § 483.15(g)

- (1) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.
- (2) A facility with more than 120 beds must employ a qualified social worker on a full-time basis.
- (3) Qualifications of social worker. A qualified social worker is an individual with -
 - (i) A bachelor's degree in social work or a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling, and psychology; and
 - (ii) One year of supervised social work experience in a health care setting working directly with individuals.

Ga. R. & Regs. § 111-8-56-.07

- (1) Each home shall provide services to assist all patients in dealing with social and related problems through one or more case-workers on the staff of the facility or through arrangements with an appropriate outside agency.
- (2) Social service information concerning each patient shall be obtained and kept. This information shall cover social and emotional factors related to the patient's condition and information concerning his home situation, financial resources and relationships with other people.
- (3) All nursing personnel and employees having contact with patients shall receive social service orientation and inservice training toward understanding emotional problems and social needs of patients.
- (4) One person in each home shall be designated as being responsible for the social services aspects of care in the home.

Rehabilitative Services

42 C.F.R. § 483.45

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

(1) Provide the required services; or

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

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

Ga. R. & Regs. § 111-8-56-.09

(1) When a home has a physical therapy program, the services must be provided or directly supervised by a physical therapist.

(2) A therapy record will be kept as a part of the medical record on each patient receiving physical therapy. Information in the medical record shall include referral, diagnosis, precautions, initial physical therapy evaluation treatment plan and objectives, frequency and dates of medical reevaluations.

(3) The physical therapist shall keep progress notes on each patient including progress or lack of progress, symptoms noted, and changes in treatment plans.

Dental Services

42 C.F.R. § 483.55

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

- (a) Skilled nursing facilities. A facility
 - (1) Must provide or obtain from an outside resource, in accordance with § 483.75(h) of this part, routine and emergency dental services to meet the needs of each resident;
 - (2) May charge a Medicare resident an additional amount for routine and emergency dental services;
 - (3) Must if necessary, assist the resident -
 - (i) In making appointments; and
 - (ii) By arranging for transportation to and from the dentist's office; and
 - (4) Promptly refer residents with lost or damaged dentures to a dentist.
- (b) Nursing facilities. The facility
 - (1) Must provide or obtain from an outside resource, in accordance with § 483.75(h) of this part, the following dental services to meet the needs of each resident:
 - (i) Routine dental services (to the extent covered under the State plan); and
 - (ii) Emergency dental services;
 - (2) Must, if necessary, assist the resident -
 - (i) In making appointments; and
 - (ii) By arranging for transportation to and from the dentist's office; and
 - (3) Must promptly refer residents with lost or damaged dentures to a dentist.

Pharmacy Services and Medications

42 C.F.R. § 483.60

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

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

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

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

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

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

(c) Drug regimen review.

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

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

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

(e) Storage of drugs and biologicals.

(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

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

Unnecessary drugs:

42 C.F.R. § 483.25 (l)—

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

- (i) In excessive dose (including duplicate drug therapy); or
- (ii) For excessive duration; or
- (iii) Without adequate monitoring; or
- (iv) Without adequate indications for its use; or
- (v) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or
- (vi) Any combinations of the reasons above.

Antipsychotic drugs:

42 C.F.R. § 483.25 (2) Based on a comprehensive assessment of a resident, the facility must ensure that—

- (i) Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and
- (ii) Residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

Medication errors:

42 C.F.R. § 483.25 (m) The facility must ensure that—

- (1) It is free of medication error rates of five percent or greater; and
- (2) Residents are free of any significant medication errors.

O.C.G.A. § 31-8-110

(a) Each resident or guardian shall be permitted to select the pharmacy or pharmacist of his choice for those pharmaceutical supplies and services not provided by the facility as a part of the basic rate. However, if the facility under its policies or procedures utilizes a specific type of unit dose system, such pharmacy or pharmacist must provide pharmaceuticals under such system. The resident or guardian shall be informed in writing at the time of admission of the resident as to which pharmaceutical supplies and services are not so provided.

(b) No person shall be discriminated against as to admission or continued residency on the basis of the person's choice of pharmacy, pharmacist, or both.

(c) Subject to the resident's choice of pharmacy or pharmacist, each resident shall receive pharmaceutical supplies and services at reasonable prices not exceeding applicable and normally accepted prices for comparably packaged pharmaceutical supplies and services within the community.

(d) Each resident or guardian shall, on his request, be informed of the identity, purpose, and possible reactions to each drug to be administered.

Ga. R. & Regs. § 111-8-56-.08

Each home shall provide pharmaceutical services in full compliance with State and Federal laws and regulations.

Ga. R. & Regs. 111-8-56-.10

(6) All medications, administered to patients must be ordered in writing by the patient's physician or oral orders may be given to a licensed nurse, immediately reduced to writing, signed by the nurse and countersigned by the physician as soon as practical.

(a) Medications not specifically limited as to time or number of doses, when ordered, must be automatically stopped in accordance with written policy approved by the organized professional staff.

(b) The patient's attending physician shall be notified of stop order policies and contacted promptly for renewal of such orders so that continuity of the patient's therapeutic regimen is not interrupted.

(7) All medications must be administered by medical or nursing personnel in accordance with the Medical and Nurse Practice Acts of the State of Georgia. Each dose administered shall be properly recorded in the clinical records:

(a) The nurses' station shall have readily available items necessary for the proper administration of medication;

(b) In administering medications, medication cards or other State approved systems must be used and checked against the physician's orders;

(c) Legend drugs prescribed for one patient shall not be administered to any other patient unless ordered by a physician;

(d) Self-administration of medications by patients should be discouraged except for emergency drugs on special order of the patient's physician or in a predischarge program under the supervision of a licensed nurse;

(e) Medication errors and drug reactions shall be immediately reported to the patient's physician and an entry thereof made in the patient's clinical records as well as on an incident report;

(f) Up-to-date medication reference texts and sources of information shall be available.

CMS's 2016/2017 action plan indicates that polypharmacy with respect to dementia residents is a problem area needing improvement:¹⁵

Antipsychotic medications are frequently prescribed off label to residents with dementia related behavioral and psychological symptoms (BPSD). This has led to increased attention to the behavioral health management of nursing home residents and the potentially inappropriate use of antipsychotics in this population. Evidence suggests that antipsychotics have limited benefits in this population, and the potential for adverse

¹⁵ <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Downloads/2016-2017-Nursing-Home-Action-Plan.pdf>.

consequences such as the risk of movement disorders, falls, hip fractures, cerebrovascular accidents, and death. Additionally, nursing home residents are medically complex and take multiple medications that increase their risk of adverse effects and drug interactions.

Based on continued evidence that nursing home residents are at risk for adverse events due to polypharmacy and overuse of many different types of medications, CMS has undertaken a national partnership with collaborative parties both internally and externally. This partnership currently focuses on one particular class of medications, antipsychotics, in an effort to reduce the overall use of these agents in nursing homes. However, as outlined in F329, DNH still expects surveyors to evaluate other important classes of medications for unnecessary use, such as antibiotics, anticoagulants, proton pump inhibitors and others (F329 focuses on the importance of looking at all medications as well as implementation of non-pharmacological approaches to optimize the care of residents in nursing homes). The DNH is taking a multidimensional approach to improving the quality of care provided to individuals with dementia living in nursing homes.

The potential overuse of antipsychotic agents is a symptom of a much larger problem – namely that many nursing home providers may not have a systematic plan to provide comprehensive behavioral health management to residents with diagnoses such as dementia and BPSD. DNH believes that the intent of OBRA '87 and current regulations already support a number of essential elements that must be in place in order for nursing homes to be in compliance with federal regulations on quality of care and quality of life related to behavioral health.

Pressure Sores

42 C.F.R. § 483.25(c)

Based on the comprehensive assessment of a resident, the facility must ensure that—

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

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

Appendix PP, F314

“Pressure Ulcer” - A pressure ulcer is any lesion caused by unrelieved pressure that results in damage to the underlying tissue(s).¹⁵ Although friction and shear are not primary causes of pressure ulcers, friction and shear are important contributing factors to the development of pressure ulcers.

- “Avoidable/Unavoidable” Pressure Ulcers
 - “Avoidable” means that the resident developed a pressure ulcer and that the facility did not do one or more of the following: evaluate the resident’s clinical condition and pressure ulcer risk factors; define and implement interventions that are consistent with resident needs, resident goals, and recognized standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate.
 - “Unavoidable” means that the resident developed a pressure ulcer even though the facility had evaluated the resident’s clinical condition and pressure ulcer risk factors; defined and implemented interventions that are consistent with resident needs, goals, and recognized standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate.

...

Risk Factors

Many studies and professional documents identify risk factors that increase a resident’s susceptibility to develop or to not heal pressure ulcers. Examples of these risk factors include, but are not limited to:

- Impaired/decreased mobility and decreased functional ability;
- Co-morbid conditions, such as end stage renal disease, thyroid disease or diabetes mellitus;
- Drugs such as steroids that may affect wound healing;

- Impaired diffuse or localized blood flow, for example, generalized atherosclerosis or lower extremity arterial insufficiency;
- Resident refusal of some aspects of care and treatment;
- Cognitive impairment;
- Exposure of skin to urinary and fecal incontinence;
- Under nutrition, malnutrition, and hydration deficits; and
- A healed ulcer. The history of a healed pressure ulcer and its stage [if known] is important, since areas of healed Stage III or IV pressure ulcers are more likely to have recurrent breakdown.

Clinical practice guidelines¹⁶ indicate that the following are high-risk diagnoses:

- Peripheral vascular disease
- Myocardial infarction
- Stroke
- Multiple trauma
- Musculoskeletal disorders/fractures/contractures
- Gastrointestinal bleed
- Spinal cord injury (e.g., decreased sensory perception, muscle spasms)
- Neurological disorders (e.g., Guillain-Barré, multiple sclerosis)
- Unstable and/or chronic medical conditions (e.g., diabetes, renal disease, cancer, chronic obstructive pulmonary disease, congestive heart failure)
- History of previous pressure ulcer
- Preterm neonates
- Dementia
- Recent surgical patient. Individuals who undergo operative procedures may be at increased risk for pressure ulcers. This risk may be related to length of time on the operating room/procedure table, hypotension or to the type of procedure.

The following mnemonics identify the components of a treatment plan for symptom management:

S-P-E-C-I-A-L

S = Stabilize the wound

P = Prevent new wounds

E = Eliminate odor

C = Control pain

I = Infection prophylaxis

A = Advanced absorbent wound dressing

L = Lessen dressing changes as palliation care occurs

¹⁶ Institute for Clinical Systems Improvement Pressure ulcer prevention and treatment protocol (January 2008, revised January 2012), available at www.guideline.gov

Urinary Incontinence

42 C.F.R. § 483.25 (d)

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

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

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

Appendix PP, F315

Range of Motion

42 C.F.R. § 483.25 (e)

Based on the comprehensive assessment of a resident, the facility must ensure that—

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

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

Appendix PP, F317 & F318

Mental and Psychosocial Functioning

42 C.F.R. § 483.25 (f)

Based on the comprehensive assessment of a resident, the facility must ensure that—

- (1) A resident who displays mental or psychosocial adjustment difficulty, receives appropriate treatment and services to correct the assessed problem, and
- (2) A resident whose assessment did not reveal a mental or psychosocial adjustment difficulty does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that such a pattern was unavoidable.

Appendix PP, F319 & F320

Naso-gastric tubes

42 C.F.R. § 483.25 (g)

Based on the comprehensive assessment of a resident, the facility must ensure that—

- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso-gastric tube unless the resident's clinical condition demonstrates that use of a naso-gastric tube was unavoidable; and
- (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.

Appendix PP, F322

Accidents & Environment

In reviewing the plan of care, decisions are reached concerning Mable's care. One of Sally's concerns is that Mable has sufficient supervision to avoid falls. The staff indicates that Mable will be safe, but falls are to be expected and they do not provide one on one care.

Example: John is admitted to Happy Acres and is assessed as a fall risk. He is on Coumadin and is confused (or has mild dementia). John is left unattended in his wheelchair. He attempts to walk, falls and has a head injury.

Example: John is known to wander. Happy Areas does not secure the doors leading to its loading dock. John wanders through that door, falls off the loading dock, and is injured.

42 C.F.R. § 483.25 (h). The facility must ensure that—

- (1) The resident environment remains as free of accident hazards as is possible; and
- (2) Each resident receives adequate supervision and assistance devices to prevent accidents.

Appendix PP, F323

42 C.F.R. § 483.15(h)

The facility must provide -

- (1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible;
- (2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;
- (3) Clean bed and bath linens that are in good condition;
- (4) Private closet space in each resident room, as specified in § 483.70(e)(2)(iv) of this part;
- (5) Adequate and comfortable lighting levels in all areas;
- (6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71-81 °F; and
- (7) For the maintenance of comfortable sound levels.

Infection Control:

42 C.F.R. § 483.65

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

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

- (1) Investigates, controls, and prevents infections in the facility;
 - (2) Decides what procedures, such as isolation, should be applied to an individual resident; and
 - (3) Maintains a record of incidents and corrective actions related to infections.
- (b) Preventing spread of infection.
- (1) When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
 - (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
 - (3) The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice.
- (c) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

Physical environment:

42 C.F.R. § 483.70

The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public.

(a) Life safety from fire.

- (1) Except as otherwise provided in this section -
 - (i) The LTC facility must meet the applicable provisions and must proceed in accordance with the Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4.)
 - (ii) Notwithstanding paragraph (a)(1)(i) of this section, corridor doors and doors to rooms containing flammable or combustible materials must be provided with positive latching hardware. Roller latches are prohibited on such doors.
- (2) In consideration of a recommendation by the State survey agency or Accrediting Organization or at the discretion of the Secretary, may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a long-term care facility, but only if the waiver will not adversely affect the health and safety of the patients.
- (3) The provisions of the Life safety Code do not apply in a State where CMS finds, in accordance with applicable provisions of sections 1819(d)(2)(B)(ii) and 1919(d)(2)(B)(ii) of the Act, that a fire and safety code imposed by State law adequately protects patients, residents and personnel in long term care facilities.

- (4) A long-term care facility may install **alcohol-based hand rub dispensers** in its facility if the dispensers are installed in a manner that adequately protects against inappropriate access.
- (5) A long term care facility must:
- (i) Install, at least, battery-operated single station **smoke alarms** in accordance with the manufacturer's recommendations in resident sleeping rooms and common areas.
 - (ii) Have a program for inspection, testing, maintenance, and battery replacement that conforms to the manufacturer's recommendations and that verifies correct operation of the smoke alarms.
 - (iii) Exception:
 - (A) The facility has system-based smoke detectors in patient rooms and common areas that are installed, tested, and maintained in accordance with NFPA 72, National Fire Alarm Code, for system-based smoke detectors; or
 - (B) The facility is fully sprinklered in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.
- (6) A long term care facility must:
- (i) Install an approved, supervised **automatic sprinkler system** in accordance with the 1999 edition of NFPA 13, Standard for the Installation of Sprinkler Systems, as incorporated by reference, throughout the building by August 13, 2013. The Director of the Office of the Federal Register has approved the NFPA 13 1999 edition of the Standard for the Installation of Sprinkler Systems, issued July 22, 1999 for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to:
http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269.
 - (ii) Test, inspect, and maintain an approved, supervised automatic sprinkler system in accordance with the 1998 edition of NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, as incorporated by reference. The Director of the Office of the Federal Register has approved the NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 1998 edition, issued January 16, 1998 for incorporation by reference in accordance with 5 U.S.C.

552(a) and 11 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269.

(iii) Subject to approval by CMS, a long term care facility may be granted an extension of the sprinkler installation deadline for a time period not to exceed 2 years from August 13, 2013, if the facility meets all of the following conditions:

(A) It is in the process of replacing its current building, or undergoing major modifications to improve the living conditions for residents in all unsprinklered living areas that requires the movement of corridor, room, partition, or structural walls or supports, in addition to the installation of a sprinkler system; or, has had its planned sprinkler installation so impaired by a disaster or emergency, as indicated by a declaration under section 319 of the Public Health Service Act, that CMS finds it would be impractical to meet the sprinkler installation due date.

(B) It demonstrates that it has made the necessary financial commitments to complete the building replacement or modification; or pursuant to a declared disaster or emergency, CMS finds it impractical to make reasonable and necessary financial commitments.

(C) Before applying for the deadline extension, it has submitted plans to State and local authorities that are necessary for approval of the replacement building or major modification that includes the required sprinkler installation, and has received approval of the plans from State and local authorities.

(D) It agrees to complete interim steps to improve fire safety, as determined by CMS.

(iv) An extension granted under paragraph (a)(8)(iii) of this section may be renewed once, for an additional period not to exceed 1 year, if the following conditions are met:

(A) CMS finds that extenuating circumstances beyond the control of the facility will prevent full compliance with the provisions in paragraph (a)(8)(i) of this section by the end of the first waiver period.

(B) All other conditions of paragraph (a) (8) (iii) of this section are met.

(7) Buildings must have an outside window or outside door in every sleeping room, and for any building constructed after July 5, 2016 the sill height must not exceed 36 inches above the floor. Windows in atrium walls are considered outside windows for the purposes of this requirement.

(8) When a sprinkler system is shut down for more than 10 hours, the LTC facility must:

(i) Evacuate the building or portion of the building affected by the system outage until the system is back in service, or

(ii) Establish a fire watch until the system is back in service.

(b) Standard: **Building safety.** Except as otherwise provided in this section, the LTC facility must meet the applicable provisions and must proceed in accordance with the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5 and TIA 12-6).

(1) Chapters 7, 8, 12, and 13 of the adopted Health Care Facilities Code do not apply to a LTC facility.

(2) If application of the Health Care Facilities Code required under paragraph (b) of this section would result in unreasonable hardship for the LTC facility, CMS may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of residents.

(c) **Emergency power.**

(1) An emergency electrical power system must supply power adequate at least for lighting all entrances and exits; equipment to maintain the fire detection, alarm, and extinguishing systems; and life support systems in the event the normal electrical supply is interrupted.

(2) When life support systems are used, the facility must provide emergency electrical power with an emergency generator (as defined in NFPA 99, Health Care Facilities) that is located on the premises.

(d) **Space and equipment.** The facility must -

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

(2) Maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.

(e) **Resident rooms.** Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents.

(1) Bedrooms must -

(i) Accommodate no more than four residents;

(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms;

(iii) Have direct access to an exit corridor;

- (iv) Be designed or equipped to assure full visual privacy for each resident;
 - (v) In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains;
 - (vi) Have at least one window to the outside; and
 - (vii) Have a floor at or above grade level.
- (2) The facility must provide each resident with -
- (i) A separate bed of proper size and height for the convenience of the resident;
 - (ii) A clean, comfortable mattress;
 - (iii) Bedding appropriate to the weather and climate; and
 - (iv) Functional furniture appropriate to the resident's needs, and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident.
- (3) CMS, or in the case of a nursing facility the survey agency, may permit variations in requirements specified in paragraphs (d)(1) (i) and (ii) of this section relating to rooms in individual cases when the facility demonstrates in writing that the variations -
- (i) Are in accordance with the special needs of the residents; and
 - (ii) Will not adversely affect residents' health and safety.
- (f) **Toilet facilities.** Each resident room must be equipped with or located near toilet and bathing facilities.
- (g) **Resident call system.** The nurse's station must be equipped to receive resident calls through a communication system from -
- (1) Resident rooms; and
 - (2) Toilet and bathing facilities.
- (h) **Dining and resident activities.** The facility must provide one or more rooms designated for resident dining and activities. These rooms must -
- (1) Be well lighted;
 - (2) Be well ventilated, with nonsmoking areas identified;
 - (3) Be adequately furnished; and
 - (4) Have sufficient space to accommodate all activities.
- (i) **Other environmental conditions. The facility must provide a safe, functional, sanitary, and comfortable environment for the residents, staff and the public.** The facility must -
- (1) Establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply;
 - (2) Have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two;
 - (3) Equip corridors with firmly secured handrails on each side; and
 - (4) Maintain an effective pest control program so that the facility is free of pests and rodents.

(j) The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 1 CFR part 51. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.

Ga. R. & Regs. 111-8-56-.10

(5) The home shall have a microbial and infection control program. Policies and procedures for infection control shall be written, assembled and available to all staff members.

Procedures shall be specific for practice in the home and shall be included in the training of every staff member. As a minimum, procedures shall include the following control measures:

(a) Prevention of spread of infection from personnel to patient: Any person whose duties include direct patient care, handling food, or handling clean linen, and who has an acute illness such as "strep" throat, or an open sore or boil, shall not be allowed to work until he is fully recovered;

(b) Prevention of spread of infection from visitors to patients;

(c) Prevention of spread of infection from patient to personnel or other patients: Isolation techniques to be observed according to the source of infection and the method of spread;

(d) Reporting of communicable diseases as required by the rules and regulations for notification of diseases which have been promulgated by the Department.

Ga. R. & Regs. 111-8-56-.10

(10) Provisions shall be made for proper sterilization of supplies, utensils, instruments, and other materials as needed for the patients.

Ga. R. & Regs. 111-8-56-.12

(1) Patient beds shall be single, at least thirty-six inches wide, with firm even springs covered by a mattress not less than four inches thick.

(2) The home shall provide all linens and blankets essential to the treatment and comfort of patients.

(3) Wheelchairs, walkers, and mechanical lifters shall be provided by the home when needed.

(4) Each patient shall have necessary furniture which shall include a bedside table, a reading lamp, a chair, drawer space for clothes, enclosed space for hanging clothing, and individual towel rack, soap dish, drinking glass, and access to a mirror. Each patient shall have a suitable signaling device.

(5) Individual equipment shall be cleaned after each use and disinfected at least once each week. Equipment such as bedpans, urinals and wash basins, if not individual, should be disinfected after each use.

(6) Each patient shall be provided adequate supplies and equipment for proper oral hygiene including a toothbrush or a denture brush and denture receptacle when needed.

(7) Bedrails shall be available for use as required by the patient's condition.

(8) There shall be an electric clock with a bold face that can be read from a distance of twenty (20) feet installed in the lobby of each home.

(9) Disposable equipment and supplies shall be used only once and disposed of in an approved manner.

Ga. R. & Regs. § 111-8-56-.13

(1) All buildings and equipment shall be maintained in such condition that no hazards to the life and safety of the patients exist.

(2) Adequate parking shall be available nearby. Parking areas and service entrances shall be so designated that fire fighting equipment will have unobstructed access to all parts of the building.

(3) Handrails shall be provided on all stairways and ramps. Stairways shall be made of or covered with safe nonslip material. Doors opening onto stairways shall not open directly onto risers, but shall open onto a landing not less than the width of the door.

(4) Safety barriers at the head of stairways, and handrails in hallways shall be provided. There shall be no low windows, open porches, changes in floor levels or similar hazards.

(5) Doors to rooms used by patients shall be equipped with locks or other devices which will not allow the room to be locked from the inside.

(6) Floor surfaces shall be smooth and level; scatter rugs and highly polished floors in patient areas are prohibited.

(7) Showers, tubs and toilets shall have grab bars firmly installed convenient to patient use; the floor in bathing areas shall be provided with a nonslip surface. No patient shall be permitted to bathe without an available attendant to regulate water temperature and to provide generally for the safety of the patient, unless the patient's physician has provided a written statement to the effect that the patient is sufficiently responsible to bathe himself. Shower heads shall not be installed above bathtubs.

(8) Warning signs shall be posted prohibiting smoking or open flames of any kind in areas where oxygen is in use or stored.

See Nursing home may shut down after inspection cited problems, at

http://www.stltoday.com/sports/nursing-home-may-shut-down-after-inspection-cited-problems/article_1248e4d3-1c01-5f7d-bfd1-2f3bcfa56e9d.html.

Nutrition

Example: John hates cabbage and his dislike for it is listed on his dietary preferences chart. He has complained previously, informing the staff that cabbage gives him diarrhea. The facility nonetheless serves his tray with cabbage as his vegetable.¹⁷

42 C.F.R. § 483.25 (i). Based on a resident's comprehensive assessment, the facility must ensure that a resident—

- (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and
- (2) Receives a therapeutic diet when there is a nutritional problem.

Appendix PP, F325

Suggested parameters for evaluating significance of unplanned and undesired weight loss are:

Interval	Significant Loss	Severe Loss
1 month	5%	Greater than 5%
3 months	7.5%	Greater than 7.5%
6 months	10%	Greater than 10%

42 C.F.R. § 483.35

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

42 C.F.R. § 483.35(c) through (g)

(c) Menus and nutritional adequacy. Menus must -

- (1) Meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences;
- (2) Be prepared in advance; and
- (3) Be followed.

(d) Food. Each resident receives and the facility provides -

- (1) Food prepared by methods that conserve nutritive value, flavor, and appearance;
- (2) Food that is palatable, attractive, and at the proper temperature;
- (3) Food prepared in a form designed to meet individual needs; and

¹⁷ This example is based on an inspection report available through Medicare.gov. The FTag cited was F 0232.

- (4) Substitutes offered of similar nutritive value to residents who refuse food served.
- (e) Therapeutic diets. Therapeutic diets must be prescribed by the attending physician.
- (f) Frequency of meals.
 - (1) Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.
 - (2) There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided in (4) below.
 - (3) The facility must offer snacks at bedtime daily.
 - (4) When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.
- (g) Assistive devices. The facility must provide special eating equipment and utensils for residents who need them.

Ga. R. & Regs. § 111-8-56-06

- (1) Each home shall employ the services of a qualified dietitian (American Dietetic Association or equivalent qualifications). The services of the dietitian shall not be less than eight (8) hours per month.
- (2) Meals, adequate as to quantity and quality, shall be served in sufficient numbers with a maximum of five (5) hours apart with no longer than fourteen (14) hours between the evening meal and breakfast. Between meal and bedtime snacks shall be offered each patient.
- (3) A nutritionally adequate diet shall be provided all patients and adjusted to patient's age, sex, activity, and physical condition. Nutrient concentrates and supplements shall be given only on written order of a physician.
- (4) Menus shall be planned or approved by a qualified dietitian and dated. Used menus shall be kept on file for a period of thirty days for reference by the patient's physician and personnel of the home.
- (5) Modified diets shall be provided in accordance with written orders of a physician or dentist. An approved diet manual shall be readily available to food service personnel.
- (6) Sufficient perishable foods for a twenty-four hour period and nonperishable foods for a three-day period shall be on the premises for use in an emergency.

Hydration

Example: John had a stroke and cannot use his left hand. CNAs attending to him routinely bring his water and place it on his left side. They charted that he does not appear to want water.

42 C.F.R. § 483.25 (j). The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.

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The signs and symptoms of dehydration range from minor to severe and include:

- Increased thirst
- Dry mouth and swollen tongue
- Weakness
- Dizziness
- Palpitations (feeling that the heart is jumping or pounding)
- Confusion
- Sluggishness fainting
- Fainting
- Inability to sweat
- Decreased urine output

Urine color may indicate dehydration. If urine is concentrated and deeply yellow or amber, you may be dehydrated.

See B. Popkin, K. D'Anci and I. Rosenberg, *Water, Hydration and Health*, available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2908954/>

Special Needs

42 C.F.R. § 483.25 (k). The facility must ensure that residents receive proper treatment and care for the following special services:

- (1) Injections;
- (2) Parenteral and enteral fluids;
- (3) Colostomy, ureterostomy, or ileostomy care;
- (4) Tracheostomy care;
- (5) Tracheal suctioning;
- (6) Respiratory care;
- (7) Foot care; and
- (8) Prostheses.

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Cause of Action for Violating Rights

O.C.G.A. § 31-8-126

(a) Any person or persons aggrieved because a long-term care facility has violated or failed to provide any right granted under this article shall have a cause of action against such facility for damages and such other relief as the court having jurisdiction of the action deems proper. No person shall be prohibited from maintaining such an action for failure to exhaust any rights to administrative or other relief granted under this article.

(b) In addition to other penalties or remedies that may be imposed by this article or other law, the department is authorized to impose civil penalties as follows:

(1) If a violation has occurred, the department shall order the facility to correct such violation. Upon failure to correct such violation within a reasonable period of time, the department may order the facility to discontinue admitting residents until such violation is corrected; and

(2) In cases of violations repeated by a facility under the same license within a 12 month period, the department shall be authorized to assess a civil penalty not to exceed \$75.00 per violation for each day in which the violation continues, except that the maximum civil penalty for each violation shall not exceed \$2,500.00. In imposing such civil penalties the department shall consider all relevant factors including, but not limited to:

(A) The amount of assessment necessary to ensure immediate and continued compliance;

(B) The character and degree of impact of the violation of the health, safety, and welfare of any resident in the nursing home;

(C) The conduct of the person or facility against whom the citation is issued in taking all feasible steps or procedures necessary or appropriate to comply or to correct the violations; and

(D) Any prior violations by the facility of statutes, regulations, or orders administered, adopted, or issued by the department.

(c) Any such civil penalty shall be imposed by the department only after notice and hearing as provided in Article 1 of Chapter 5 of this title.

(d) Any person or facility subject to a civil penalty under this Code section is entitled to judicial review in accordance with Article 1 of Chapter 5 of this title.

(e) All civil penalties recovered by the department under this Code section shall be paid into the state treasury.

(f) Nothing in this Code section shall be construed to preempt any other law or to deny to any individual any rights or remedies which are provided by or under any other law.

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

Malpractice

If you suspect malpractice, then you should consult a nursing home litigation attorney. We usually recommend Lance Lourie of Watkins, Lourie, Roll & Chance in Atlanta, Georgia. They are able to litigate cases virtually anywhere and have a strong history of securing good results. (404) 760-7400.

When examining your case, the litigation attorney will be looking at the following:

1. What's the patient like? Are they good people (or would a jury hate them)	Many litigators try to explain a nursing home's duty and breach of that duty in simple terms by using the acronym "POP" Is it p redictable, Is it o bservable? If so, then it's usually p reventable.
2. Family: Are they good people (do they make good witnesses or would a jury hate them)	
3. Duty and breach of duty (did the nursing home have a responsibility to do or not do something, and did the nursing home breach that duty?)	
4. Causation	
5. Damages	