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Medicaid and Nursing Home Advocacy

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Note: This document is designed as a teaching tool for lawyers studying Medicaid and Nursing Home Advocacy. It is not designed as a tool for addressing your personal or family legal issues. For example, because this is a teaching tool, answers to some of the problems presented are intentionally omitted. Seek appropriate counsel from an Elder Law Attorney if you need legal advice.

"Step into the water
Wade out a little bit deeper"[1]

"You People"[2]

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

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1 http://originofsongs.blogspot.com/2013/08/step-into-water.html.

2 Ross Perot, speaking at the NAACP National Convention in Nashville, July 11, 1992. http://articles.latimes.com/1992-07-12/news/mn-4266_1_ross-perot.

accounts.[3] 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.[4]

Mable still has her mind, although she sometimes has difficulty speaking.[5] 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.[6] 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.

Decisions, Decisions!!

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 discharge planners. It's probably "smart" to consider their advice, but she could still go home if

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[3] Jacob's theft was within last 60 months. It must be disclosed if a Medicaid application is filed, but Mable should not be penalized if she took sufficient action to attempt to recover her property. States vary on what constitutes sufficient action.

[4] If the State has a Medicaid income cap, her monthly income will likely put Mable over the threshold.

[5] Mable has capacity, so her preferences are paramount in considering placement. This also means any facility she is admitted to must communicate directly with her and consider her preferences.

[6] Treatment will be required so this will not be an "observation status" admission. Discussed at http://www.medicareadvocacy.org/medicare-info/observation-status/.

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.

Mable never wanted to go to a nursing home. She recalls growing up in the World War II era and visiting her grandmother in the "Old Folks Home."[7] Like many other elders, Mable availed herself of medical technology and equipment to postpone disability.

> Nursing home use is on the decline in the United States.[8] In 1999, 18,000 nursing homes operated nation-wide, caring for 1.6 million nursing home residents.[9] In 2004, the CDC reported that 16,100 nursing homes caring for 1.5 million residents.[10] In 2011, 15,465 nursing homes were caring for 1,366,000 residents.[11] Some research attributes declining nursing home utilization to changing demographics in the aging population,[12] and to the growth in home and community-based care.[13] Other writers argue increasing restrictions on payment have forced

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7 http://www.4fate.org/history.html.

8 By 2050, one-fifth of the total U.S. population will be elderly (that is, 65 or older), up from 12 percent in 2000 and 8 percent in 1950. CBO, Rising Demand for Long-Term Services and Supports for Elderly People (June 2013), at http://www.cbo.gov/sites/default/files/cbofiles/attachments/44363-LTC.pdf.

9 *The National Nursing Home Survey: 1999 Summary* (CDC, Vital and Health Statistics, Series 12, Number 152, June 2002).

10 http://www.cdc.gov/nchs/fastats/nursingh.htm.

11 http://kff.org/other/state-indicator/number-of-nursing-facility-residents/.

12 *See Trends in Residential Long-Term Care: Use of Nursing Home and Assisted Living and Characteristics of Facilities and Residents* (Nov. 25, 2002), at http://aspe.hhs.gov/daltcp/reports/2002/rltct.htm.

13 http://scholar.harvard.edu/files/pcornell/files/assisted_living_expansion_and_the_market_for_nursi.pdf.

market efficiency.[14] Meanwhile, acuity levels for individuals who use nursing home services are rising.[15]

One of the results is that nursing home resident populations, at least those staying long-term, **are sicker**.[16] By the time a resident gets to the nursing home, his or her needs are significant.

Sally is concerned because she knows her mother. At Mable's insistence, **Sally promised** she would never admit her mother 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 are insistent that nursing home care is the only way Mable's needs will be met. The discharge planners believe it is unlikely Mable will return home.

As they consider the hospital discharge plan, Mable's family must think about the Elder Care Continuum. The continuum comprises all of the places Mable could live, or could get long-term care. It considers her needs. It considers the cost of care. It evaluates resources/benefits. The continuum then ties all elements together

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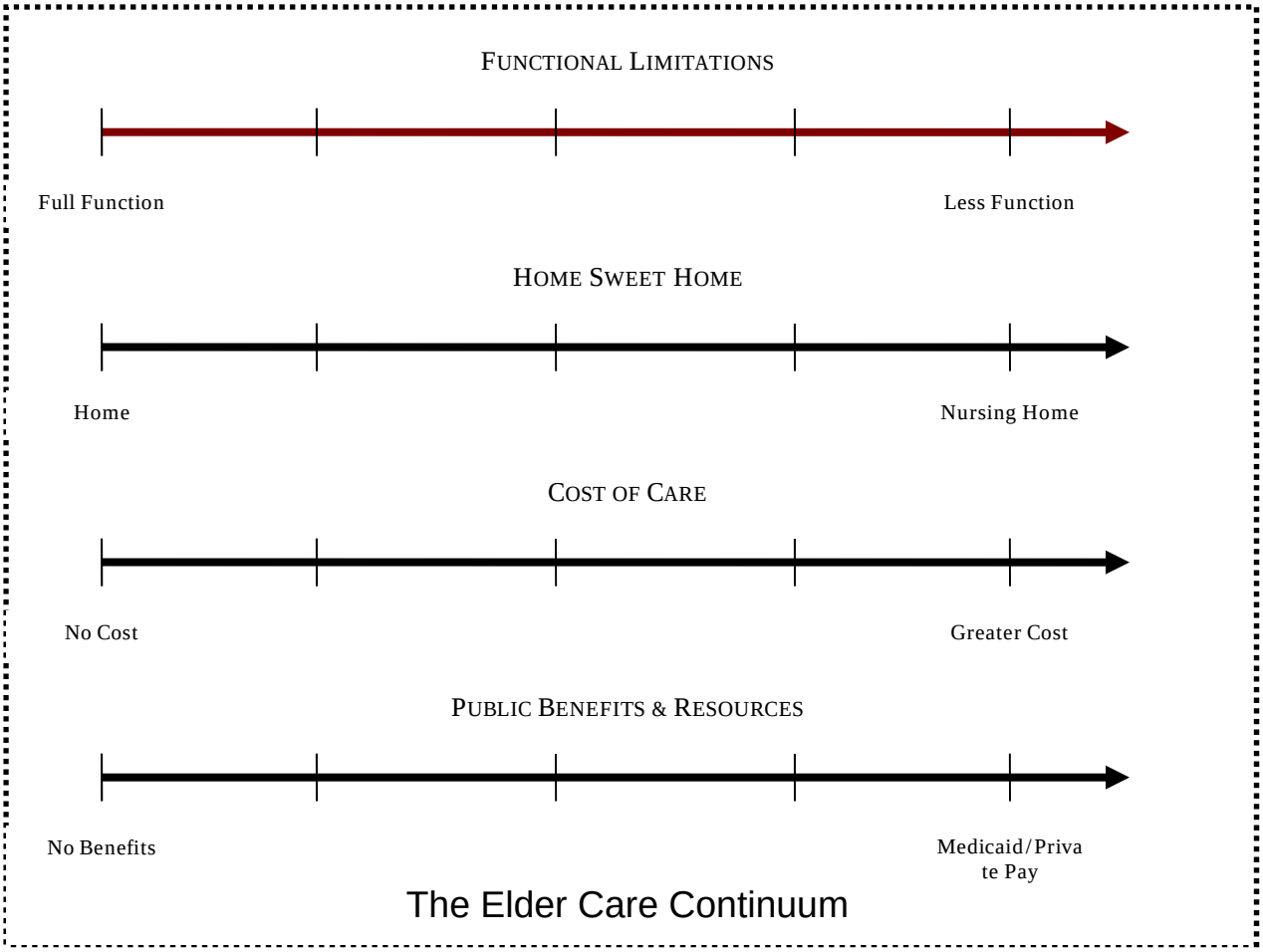
[14] J. Pratt, *supra*.

[15] Trend data from the American Health Care Association shows that resident ADL dependence has slowly risen from 3.90 in 2003 to 4.17 in 2013. http://www.ahcancal.org/research_data/trends_statistics/Documents/Trend_PVNF_FINALRPT_December2013.pdf.

[16] Sometimes referred to as the acuity level.

as Mable and her family consider resources/benefits available to pay the cost of meeting her needs in the setting of her choice.



The Elder Care Continuum

When a hospital patient is being discharged, advocacy should begin with discharge plan.[17] 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

[17] http://www.caregiver.org/caregiver/jsp/content_node.jsp?nodeid=2312.

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.[18] Medicare coverage opens doors, creating choice regarding

[18] *See* discussion of eligibility requirements in J. Stein & A. Chiplin, *2013 Medicare Handbook*, Chapter 3, § 3.03 (Aspen Publishing). Medicare will cover 100% of the first 20 days of skilled nursing care, and all but the daily co-pay (in FY2014, $152 per day) of days 21 through 100 ***if*** skilled care is required. Appropriate documentation to secure this coverage is discussed in the *2013 Medicare Handbook*.

nursing home placement 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 heath. As ample literature shows, hospital employees are often better paid and, as a result, are better trained to anticipate and plan for Mable's needs. Mable and her family should avail herself of that expertise. Third, the discharge plan is one method of communicating Mable's continuing needs to the nursing home. The plan must be placed in the medical record. Accordingly, it is available to the nursing home as the SNF develops a continuing care plan.

Paying for Care:

The cost of future care has Mable and Sally concerned.[19] They have many questions.

Medicare

They heard something about "100 Days" of nursing home care being paid for by Medicare.[20] After the 100 days, they aren't sure what happens.

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[19] In today's environment, many elders are eligible for VA Aid and Attendance (non-service connected disability payments), either directly or as surviving spouse. Those benefits are typically insufficient to pay the cost of nursing home care, so they are typically used to fund home health care or assisted living care. By regulation, when a Veteran or survivor becomes eligible for Medicaid, the VA benefit is reduced to $90 per month.

[20] http://www.medicare.gov/Pubs/pdf/10153.pdf

The skilled nursing benefit in nursing homes is discussed on the Center for Medicare Advocacy website.[21]

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.[22]

One of Sally's neighbors told Sally that she heard you have to have assets out of your name for months or years.[23] Sally's neighbor also told her that the State can seize your home after you die.[24] 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.[25] 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.

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21 http://www.medicareadvocacy.org/medicare-info/skilled-nursing-facility-snf-services/.

22 Qualified Income Trust, 42 U.S.C. § 1396p(d)(4)(B).

23 Sixty (60) months. 42 U.S.C. § 1396p(c)(1)(B). Prior to February 8, 2006, the look-back for asset transfers, other than to trust, was 36 months and the look-back for transfers to trust was 60 months.

24 42 U.S.C. § 1396p(b)(1)(B). Another common myth is that the nursing home will seize your house. The nursing home is paid by Medicaid and does not participate in Estate Recovery.

25 http://mcguffey.net/pdf/Visio-Miller%20Trust%20Diagram.pdf.

Medicaid planning is complex.[26] 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.[27] 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.[28]

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[26] A "snap-shot" of how complex Medicaid planning can be is illustrated in a chart at http://mcguffey.net/pdf/Visio-Medicaid%20Eligibility%20Basics.pdf. The chart just begins to scratch the surface though because it's impossible to plan effectively in a vacuum, not knowing the circumstances of the individual or couple needing assistance.

[27] Medicaid evaluates, but does not alter property and contract rights.

[28] Revisiting the Ethics of Medicaid Planning, p. 29, at http://mcguffey.net/pdf/NQSummer-Revisiting.pdf.

In very general terms, the statutes Medicaid planners examine are as follows:[29]

Medicaid Rules and Planning

42 U.S.C. § 1382b (*see* 42 U.S.C. § 1396(c)(2)(5) and (h)(5))[30]

(1)	Exclusion of home
(2)(A)	Exclusion of household goods
(2)(B)	Exclusion of burial space or agreement
(3)	Exclusion of property essential to self-support
(4)	Exclusion of resources part of plan to achieve self-support

42 U.S.C. § 1396p

(a)	Anti-lien provisions
(b)(1)(B)	Estate Recovery – Basic Rule
(b)(1)(C)	Long Term Care Partnership
(b)(2)(A) & (4)	Restrictions on timing of estate recovery; "estate" defined
(c)(1)(A)-(E)	Transfers of assets, look-back and penalty calculations
(c)(1)(F) & (G)	Annuities
(c)(1)(H)	Fractional transfers
(c)(1)(I)	Promissory notes, loans and mortgages
(c)(2)(A)	Permissible Transfers: Home
(c)(2)(A)(i)	To Spouse
(c)(2)(A)(ii)	To child under 21 or child who is disabled
(c)(2)(A)(iii)	To sibling with ownership interest
(c)(2)(A)(iv)	To caregiver child
(c)(2)(B)	Permissible Transfers: Other assets
(c)(2)(B)(i)	To spouse or for sole benefit of spouse
(c)(2)(B)(ii)	From spouse for sole benefit of spouse
(c)(2)(B)(iii)	To, or to trust for, disabled child
(c)(2)(B)(iv)	Trust for sole benefit of disabled person under 65
(c)(2)(C)	Intent to dispose of for FMV, exclusively for other purpose, or cure of penalty
(c)(2)(D)	Undue Hardship
(c)(3)	Joint assets
(c)(4)	Apportionment of penalty among spouses
(d)(1) – (3)	Medicaid Trust Rules
(d)(2)(A)	Exception for trusts established by Will
(d)(3)(A)	Revocable Trusts
(d)(3)(B)	Irrevocable Trusts
(d)(4)(A)	Self-Settled Special Needs Trusts
(d)(4)(B)	Income Trusts

[29] Lawyers practicing in SSI States (as opposed to 209(b) States, also spend significant time reviewing Social Security regulations and the POMS. Some States have statutes and regulations which must be consulted. Most States also have a Medicaid Manual. Georgia's Medicaid Manual, for example, is available at http://www.georgiamedicaidlaw.net/gamedicaid/.

[30] *See* 42 C.F.R. Part 416, Subpart L, *and see* POMS SI 01110.210 and related links for a more complete list of excluded assets.

(d)(4)(C)	Pooled special needs trusts
(f)	Restrictions on home equity
(g)	CCRC entrance fees

42 U.S.C. § 1396r-5

(a)(5)	Spousal impoverishment provisions apply to PACE
(b)(1)	CS income not available to IS
(b)(2)	Name on the check rule
(c)(1)	CSRA; right to assessment
(c)(2)	CSRA protected; other marital assets available to IS
(c)(3)	Assignment of support rights; spousal refusal
(c)(4)	CS's property not available to IS after eligibility
(d)	MMMNA
(d)(4)	Excess shelter allowance
(d)(5)	Court ordered support
(d)(6)	Income first rule
(e)	Right to hearing
(f)(1)	Transfer of CSRA to CS permitted
(f)(2)	Calculation of CSRA
(f)(3)	Transfers under Court order

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.

Hypothetical Three-point-five

Same facts as Hypothetical Three, except Mable will come home if her condition improves.

Hypothetical Four

Same facts as Hypothetical Three, except that Jacob did not steal money and does not have a drug habit. Instead, Jacob is disabled as a result of a motor vehicle collision. Jacob is under 65.

Hypothetical Five

Same facts as Hypothetical Four, except that Jacob is on SSI.

Back to Mable's World:

Armed with the information provided by the discharge planners, Sally sets out looking for an appropriate nursing home. There are several in her area. Sally wants Mable close to her so she can visit regularly. **But, what should she look for?**

Among the issues Sally should consider are:

A. Location, location, location.

Who cares most about Mable and her well-being? The answer to that rhetorical question is "family." One of the most important factors is whether the nursing home is located near family members who will visit. Otherwise, visits will become infrequent and Mable's care will be guided by strangers.

B. Type of Facility Needed.

Sally should try to determine Mable's needs. This may be a seemingly impossible task for persons without a health care

background if done alone. Sally should engage the health care community in discussions about Mable's needs. Sally should then ask prospective facilities whether they have the ability to meet Mable's needs. She should insist on specific responses to her questions and should not accept general assurances.

C. Visit the Facility.

A personal inspection of the facility is critical. Sally should examine more than cosmetic appearance. Perhaps the single most important factor in determining the quality of care Mable receives is the quality of the staff. Are they friendly? Are they responsive to residents and families already in the facility? Are the people there happy?

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.

Mable is admitted on physician orders.

Admission Orders	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.

Sally is certain the nursing home harvested an entire forest to collect the paper necessary to admit Mable. It's confusing at best. At worst, incomprehensible. Among the information provided was a list of Mable's rights.

Dignity	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, including each of the following rights.

Dignity	483.15(a)	(a) *Dignity*. The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

Notice of Rights	483.10(b)	(b) *Notice of rights and services.*
Rules of conduct	483.10(b)(1)	(1) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice

		(if any) of the State developed under section 1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing;

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

Right to manage funds	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.

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

Admissions Policy	483.12(d)	(d) *Admissions policy*. (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.

Sally is reluctant to sign a personal guaranty. One of the hospital discharge planners told her that Medicaid would probably pay the cost of Mable's care when Medicare played out.[31] Sally asks whether Mable will get better care if she signs a personal guarantee.

Equal access to quality health care	483.12(c)	(c) *Equal access to quality care.* (1) A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all individuals regardless of source of payment;

The admissions coordinator says that although the facility accepts Medicaid, she isn't sure Mable can stay if she applies for Medicaid. They usually require at least 3 months of private pay before someone goes on Medicaid. As far as care goes, she doesn't think it would matter. The admissions coordinator asks Sally whether she thinks Mable will apply for Medicaid. Sally says she isn't sure, but that she needs to know how Medicaid works. The

[31] 42 C.F.R. 447.15 requires the nursing home to accept Medicaid (plus the patient cost-share) as full payment if it participates in the Medicaid program.

admissions coordinator says Sally will have to talk with someone in the financial department.

Admissions Policy	483.12(d)	(d) *Admissions policy*. (1) The facility must— (i) Not require residents or potential residents to waive their rights to Medicare or Medicaid; and (ii) Not require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits.

Medicaid benefits	483.10(b)(5)	(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.

Legal rights	483.10(b)(7)	(7) The facility must furnish a

		written description of legal rights which includes... (ii) **A description of the requirements and procedures for establishing eligibility for Medicaid**, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels;
How to apply for Medicaid	483.10 (b)(10)	(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 then says even if Mable applies for Medicaid, her family must private pay while they are waiting on Medicaid approval.

"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.

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.

Comprehensive Assessment	483.20(b)	(b) *Comprehensive assessments*—(1) ***Resident assessment instrument.***[32] 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.

[32] The RAI is composed of three elements: the MDS 3.0, the care plan and the care areas assessment. The latest revision to the MDS was designed to enhance "resident voice."

		(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. (2) *When required.* Subject to the timeframes prescribed in § 413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2) (i) through (iii) of this section. The timeframes prescribed in § 413.343(b) of this chapter do not apply to CAHs. (i) **Within 14 calendar days after admission**, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, “readmission” means a return to the facility following a temporary absence for

		hospitalization or for therapeutic leave.) (ii) **Within 14 calendar days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition**.[33] (For purposes of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) (iii) **Not less often than once every 12 months**.

Quarterly review assessment	483.20(c)	(c) *Quarterly review assessment.* A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.

Accuracy of assessments	483.20(g)	(g) *Accuracy of assessments.* The assessment must accurately reflect the resident's status.

[33] The nursing process is designed to be circular: Assess, plan, treat or implement, re-assess.

Comprehensive care plans	483.20(k)	(k) *Comprehensive care plans.* (1) The facility must develop a comprehensive care plan for each resident that includes **measurable objectives and timetables** to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following— (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under § 483.25; and (ii) Any services that would otherwise be required under § 483.25 but are not provided due to the resident's exercise of rights under § 483.10, including the right to refuse treatment under § 483.10(b)(4). (2) A comprehensive care plan must be— (i) Developed within 7 days after completion of the comprehensive assessment; (ii) Prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, **and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal**

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

The assessment showed, among other things that Mable is cognitively intact. She has weakness on her left side and has mobility problems.

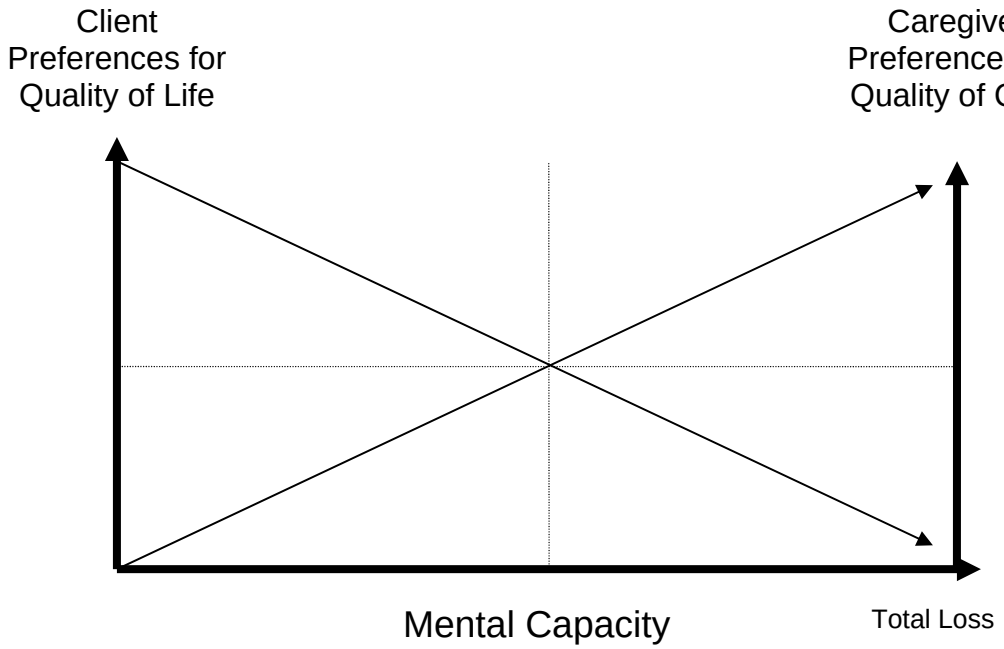
One of Sally's first questions when the care plan meeting started was **where is Mable**? She still has her mind and can make her own decisions. Why isn't she in the meeting?

Self-determination	483.15(b)	(b) *Self-determination and participation.* The resident has the right to— (1) Choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; (2) Interact with members of the community both inside and outside the facility; and (3) Make choices about aspects of his or her life in the facility that are significant to the resident.

Free Choice	483.10(d)	(d) *Free choice.* The resident has the

		right to— (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.

A competent individual should always have the right to direct his or her care, just as he or she has power to direct other aspects of his or her life. In this case, since Mable has cognitive capacity, the decision-making matrix regarding her care would mirror this chart:



Mable has always said she doesn't want to be "hooked to a machine." She doesn't want dialysis or a ventilator if it comes to that.

Right to refuse treatment	483.10(b)(4)	(4) The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section; and

Sally is concerned about Mable's emotional well-being. She mentions that fact that Mable used to be very active in her church. She asks whether there are religious services in which Mable can participate.

Participation in other activities	483.15(d)	(d) *Participation in other activities.* A resident has the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.

The care plan meeting continues, but someone goes to get Mable and she is brought in. One of the things Mable mentions is that she prefers hot tea with her meals instead of coffee.

Accommodation of needs	483.15(e)	(e) *Accommodation of needs.* A resident has the right to— (1) Reside and receive services in the facility with reasonable accommodation of individual needs and preferences,

		except when the health or safety of the individual or other residents would be endangered;
Appendix PP: "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. For issues regarding the psychosocial environment experienced by the resident, such as being ignored by staff, being made to feel unwelcome or that their care needs are burdensome to staff, refer to §483.15(a), Tag F241, Dignity.[34]		

Mable also mentions that her roommate, who appears to have dementia, has been taking her stuff and wearing her clothes.

Grievances	483.10(f)	(f) *Grievances.* A resident has the right to— (1) Voice grievances without discrimination or reprisal. Such grievances include those with respect to treatment which has been furnished as well as that which has not been furnished; and (2) Prompt efforts by the facility to resolve grievances the resident may have, <u>including those with respect to the behavior of other residents</u>.

Mable also asks what activities are available. She really doesn't like Bingo and she's bored out of her mind lying in her room. She wants to know whether there are other social activities she can become a part of.

Activities	483.15(f)	(f) *Activities.* (1) The facility must provide for an ongoing program of

[34] http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

		activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.

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.

Overview: Quality of Care	42 CFR 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.

Environment	483.15(h)	(h) *Environment.* The facility must provide— (1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible;

Physical environment	483.70	The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel

		and the public.

The staff then tells Sally that Mable's dignity and preferences must be respected and that they cannot use restraints.

Restraints	483.13(a)	(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.

The care plan meeting ends, and as they are leaving, someone on the care team approaches 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.

Access and visitation rights	483.10(j)	(j) *Access and visitation rights.* (1) The resident has the right and the facility must provide immediate access to any resident by the following: ... (iii) The resident's individual physician; (iv) The State long term care ombudsman ...; (v) ... ... (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.

Later that week, Mable decided she wanted to send a letter to her lawyer. The nursing staff, wanting to make sure everything is "ok" told her that they must review and "log" the mail before it is sealed and mailed. They also have to log mail as received so any response may take a few days before it's delivered.

Mail	483.10(i)	(i) *Mail.* The resident has the right to privacy in written communications, including the right to— (1) Send and **promptly receive** mail that is unopened; and (2) Have access to stationery, postage, and writing implements at the resident's own expense.

Sally spoke with Mable and Mable indicated that she wanted to keep seeing her doctor, Dr. Feelgood. She trusted him and he is agreeable to visiting Mable in the nursing home due to their long-standing doctor-patient relationship. However, the nursing staff

indicated that Mable could not see Dr. Feelgood and that she would have to use the staff physician.

Free Choice	483.10(d)	(d) *Free choice.* The resident has the right to— (1) Choose a personal attending physician;

When Mable entered the nursing home, her weight was 150. She has lost about 20 pounds over the last 6 weeks. Sally is getting concerned. While visiting, she noticed that the nursing aides are leaving Mable's meals on her left side.

Nutrition	483.25(i)	***Nutrition.*** Based on a resident's comprehensive assessment, the facility must ensure that a resident— **(1)** Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and **(2)** Receives a therapeutic diet when there is a nutritional problem

ADLs	483.25(a)	***Activities of daily living.*** Based on the comprehensive assessment of a resident, the facility must ensure that— **(1)** A resident's abilities in activities of daily living do not diminish unless circumstances of

		the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to— **...** **(iv)** Eat; and **(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.

Sufficient staff	483.35(b)	(b) *Sufficient staff.* The facility must employ sufficient support personnel competent to carry out the functions of the dietary service.

If Mable is having difficulty eating, then the facility is required to provide any assistive devices that would help and is required to provide sufficient staff to facilitate good nutrition. The facility may use paid feeding assistants.

Assistive devices	483.35(g)	(g) *Assistive devices.* The facility

		must provide special eating equipment and utensils for residents who need them.

Paid feeding assistants	483.35(h)	(h) *Paid feeding assistants*—(1) *State-approved training course.* A facility may use a paid feeding assistant, as defined in § 488.301 of this chapter, if— (i) The feeding assistant has successfully completed a State-approved training course that meets the requirements of § 483.160 before feeding residents; and (ii) The use of feeding assistants is consistent with State law. (2) *Supervision.* (i) A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). (ii) In an emergency, a feeding assistant must call a supervisory nurse for help on the resident call system.

Change in condition	483.10 (b)(11)	(11) *Notification of changes.* (i) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal respresentative 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);

Comprehensive Assessment	483.20(b)(2)(ii)	(b) *Comprehensive assessments* ... (2) *When required*. ... (ii) **Within 14 calendar days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition**. (For purposes of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)

While helping Mable change clothes, Sally notices a pressure ulcer on Mable's sacrum. There were no pressure ulcers when Mable was admitted.

Pressure Ulcers	483.25(c)	***Pressure sores.*** Based on the comprehensive assessment of a resident, the facility must ensure that— **(1)** A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and **(2)** A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing

Litigation considerations:

1. Mable: what's she like?	**POP**:
2. Family: Are they likable?	Is it **p**redictable, and
3. Duty, breach?	Is it **o**bservable?
4. Causation	If so, then it's **p**reventable.
5. Damages	

Even when an individual's rights have been violated, litigation counsel must consider unseemly issues such as the cost of proving

the cost.[35] In situations where the injury is slight, the cost of justice might make it impossible to support the litigation. Most litigated nursing home claims involve death or serious injury such as a fall or the development of pressure ulcers.

Sally finds these developments troubling and asks when the doctor will be by to check on Mable. She is told the doctor was just there and it will be another month before he returns. However, when she speaks with Mable, Sally is informed that Mable never saw the doctor.

Physician visits	483.40(b)	(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.
Frequency of	483.40(c)	(c) *Frequency of physician visits.*

[35] Also worth noting is that the nursing home quality of care statutes and regulations do not create a private right of action. In other words, you cannot sue a nursing home and simply allege, you violated the federal regulations so "pay me." The first case to address this issue was *Brogdon v. National Healthcare Corporation*, 103 F. Supp. 2nd 1322 (N.D.Ga. May 17, 2000 and June 26 2000). Although it is not negligence per se to violate the quality of care regulations, State law might permit their use as evidence of the standard of care.

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.

Contacting physician	483.10(b)(9)	(9) The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

Still troubled, Sally requests a copy of Mable's chart. She is told the chart is "confidential" and that she cannot see it.

Access to Records	483.10(b)(2)	(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.

Troubled still, Sally continues asking questions. The Director of Nursing determines that Sally is a problem family member and the facility would be better off without Mable. They issue a discharge notice, hoping to get them out of the facility.

Transfer and discharge requirements	483.12(a)(2)	(2) *Transfer and discharge requirements.* The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless— **(i)** The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; **(ii)** The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; **(iii)** The safety of individuals in the facility is endangered; **(iv)** The health of individuals in the facility would otherwise be

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

Sally and Mable are unable to work out their differences with Mercy Me so they decide Mable will move to another facility.

Documentation	483.12(a)(3)	(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.

Orientation	483.12(a)(7)	(7) *Orientation for transfer or*

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

Discharge summary	483.20(l)	(l) *Discharge summary*. When the facility anticipates discharge a resident must have a discharge summary that includes— (1) A recapitulation of the resident's stay; (2) A final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative; and (3) A post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.

Conclusion

Don't let this be your grandmother: "My poor Gigi, who was such a strong and confident woman, became a shell. The 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."[36]

[36] http://www.medical-directions.com/category/healthy-living/.

Nursing Home Regulations

The federal nursing home regulations cover two primary domains: dignity and health.

Scope and Definitions

			Notes and Cross References
Basis and Scope	483.1	(a) *Statutory basis.* (1) Sections 1819 (a), (b), (c), and (d) of the Act provide that— (i) Skilled nursing facilities participating in Medicare must meet certain specified requirements; and (ii) The Secretary may impose additional requirements (see section 1819(d)(4)(B)) if they are necessary for the health and safety of individuals to whom services are furnished in the facilities. (2) Section 1861(l) of the Act requires the facility to have in effect a transfer agreement with a hospital. (3) Sections 1919 (a), (b), (c), and (d) of the Act provide that nursing facilities participating in Medicaid must meet certain specific requirements. (b) *Scope.* The provisions of this part contain the requirements that an institution must meet in order to qualify to participate as a SNF in the Medicare program, and as a nursing facility in the Medicaid program. They serve as the basis for survey activities for the purpose of determining whether a facility meets the requirements for participation in Medicare and Medicaid	42 U.S.C. § 1395i-3 (Medicare) 42 U.S.C. § 1396r (Medicaid) State Operations Manual, Appendix PP
Facility defined	483.5(a)	(a) *Facility defined.* For purposes of this subpart, *facility* means a skilled nursing facility (SNF) that meets the requirements of sections 1819(a), (b), (c), and (d) of the Act, or a nursing facility (NF) that meets the requirements of sections 1919(a), (b), (c), and (d) of the Act. "Facility" may include a distinct part of an institution (as defined in paragraph (b) of this section and specified in § 440.40 and § 440.155 of this chapter), but does not include an institution for the mentally retarded or persons with related conditions described in § 440.150 of this chapter. For Medicare and Medicaid purposes (including eligibility, coverage, certification, and payment), the "facility" is always the entity that participates in the program, whether that entity is comprised of all of, or	42 U.S.C. § 1396r(a) (nursing facility defined) 42 U.S.C. § 1395i-3(a) Ga. R. & Regs. 111-8-56.-01(a) and (b)

				Notes and Cross References
			a distinct part of, a larger institution. For Medicare, an SNF (*see* section 1819(a)(1) of the Act), and for Medicaid, an NF (*see* section 1919(a)(1) of the Act) may not be an institution for mental diseases as defined in § 435.1010 of this chapter.	
	Distinct Part	483.5(b)(1)	(b) *Distinct part*—(1) *Definition.* A distinct part SNF or NF is physically distinguishable from the larger institution or institutional complex that houses it, meets the requirements of this paragraph and of paragraph (b)(2) of this section, and meets the applicable statutory requirements for SNFs or NFs in sections 1819 or 1919 of the Act, respectively. A distinct part SNF or NF may be comprised of one or more buildings or designated parts of buildings (that is, wings, wards, or floors) that are: In the same physical area immediately adjacent to the institution's main buildings; other areas and structures that are not strictly contiguous to the main buildings but are located within close proximity of the main buildings; and any other areas that CMS determines on an individual basis, to be part of the institution's campus. A distinct part must include all of the beds within the designated area, and cannot consist of a random collection of individual rooms or beds that are scattered throughout the physical plant. The term “distinct part” also includes a composite distinct part that meets the additional requirements of paragraph (c) of this section.	Ga. R. & Regs. 111-8-56.-01(d)
	Requirements	483.5(b)(2)	2) *Requirements.* In addition to meeting the participation requirements for long-term care facilities set forth elsewhere in this subpart, a distinct part SNF or NF must meet all of the following requirements: (i) The SNF or NF must be operated under common ownership and control (that is, common governance) by the institution of which it is a distinct part, as evidenced by the following: (A) The SNF or NF is wholly owned by the institution of which it is a distinct part. (B) The SNF or NF is subject to the by-laws and operating decisions of a common governing body. (C) The institution of which the SNF or NF is a distinct part has final responsibility for the distinct part's administrative decisions and personnel policies, and final approval	

				Notes and Cross References
			for the distinct part's personnel actions. (D) The SNF or NF functions as an integral and subordinate part of the institution of which it is a distinct part, with significant common resource usage of buildings, equipment, personnel, and services. (ii) The administrator of the SNF or NF reports to and is directly accountable to the management of the institution of which the SNF or NF is a distinct part. (iii) The SNF or NF must have a designated medical director who is responsible for implementing care policies and coordinating medical care, and who is directly accountable to the management of the institution of which it is a distinct part. (iv) The SNF or NF is financially integrated with the institution of which it is a distinct part, as evidenced by the sharing of income and expenses with that institution, and the reporting of its costs on that institution's cost report. (v) A single institution can have a maximum of only one distinct part SNF and one distinct part NF. (vi) (A) An institution cannot designate a distinct part SNF or NF, but instead must submit a written request with documentation that demonstrates it meets the criteria set forth above to CMS to determine if it may be considered a distinct part. (B) The effective date of approval of a distinct part is the date that CMS determines all requirements (including enrollment with the fiscal intermediary (FI)) are met for approval, and cannot be made retroactive. (C) The institution must request approval from CMS for all proposed changes in the number of beds in the approved distinct part.	
Composite Distinct Part	483.5(c)		(c) *Composite distinct part*—(1) *Definition.* A composite distinct part is a distinct part consisting of two or more noncontiguous components that are not located within the same campus, as defined in § 413.65(a)(2) of this chapter. (2) *Requirements.* In addition to meeting the requirements of paragraph (b) of this section, a composite distinct part must meet all of the following requirements: (i) A SNF or NF that is a composite of more than one location will be treated as a single distinct part of the institution of which it is a distinct part. As such, the composite distinct part will have only one provider agreement	

				Notes and Cross References
			and only one provider number. (ii) If two or more institutions (each with a distinct part SNF or NF) undergo a change of ownership, CMS must approve the existing SNFs or NFs as meeting the requirements before they are considered a composite distinct part of a single institution. In making such a determination, CMS considers whether its approval or disapproval of a composite distinct part promotes the effective and efficient use of public monies without sacrificing the quality of care. (iii) If there is a change of ownership of a composite distinct part SNF or NF, the assignment of the provider agreement to the new owner will apply to all of the approved locations that comprise the composite distinct part SNF or NF. (iv) To ensure quality of care and quality of life for all residents, the various components of a composite distinct part must meet all of the requirements for participation independently in each location.	
	Common area	483.5(d)	(d) *Common area.* Common areas are dining rooms, activity rooms, meeting rooms where residents are located on a regular basis, and other areas in the facility where residents may gather together with other residents, visitors, and staff.	
	Fully sprinklered	483.5(e)	(e) *Fully sprinklered.* A fully sprinklered long term care facility is one that has all areas sprinklered in accordance with National Fire Protection Association 13 "Standard for the Installation of Sprinkler Systems" without the use of waivers or the Fire Safety Evaluation System.	483.70(a) (Life safety from fire)

Dignity

			Notes and Cross References
Dignity	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	42 U.S.C. § 1396r(b)(1)(A) 42 U.S.C. § 1395i(b)(1)(A) 42 C.F.R. § 483.15(a)

				Notes and Cross References
			rights of each resident, including each of the following rights.	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. Appendix PP:[1] "Section 483.10 is intended to lay the foundation for the remaining resident rights requirements which cover more specific areas." "A facility must promote the exercise of rights for each resident, including any who face barriers (such as communication problems, hearing problems and cognition limits) in the exercise of these rights. A resident, even though determined to be incompetent, should be able to assert these rights based on his or her degree of capability."
	Exercise of Rights	483.10(a)(1) and (2)	(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.	O.C.G.A. § 31-8-111 O.C.G.A. § 31-8-118(a) Appendix PP, F151 "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."
	Surrogates	483.10(a)(3)	(3) In the case of a resident adjudged incompetent under the laws of a State by a court of competent	O.C.G.A. § 31-8-102(4): "Representative" means a person authorized by a resident or his guardian to act for the

[1] State Operations Manual, Appendix PP – Guide to Surveyors for Long-Term Care Facilities, available at: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf.

			Notes and Cross References
	and (4)	jurisdiction, the rights of the resident are exercised by the person appointed under State law to act on the resident's behalf.[2] (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.[3]	resident as an official delegate or agent. Appendix PP, F152 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.
Notice of Rights	483.10(b)	(b) *Notice of rights and services.*	O.C.G.A. § 31-8-105.
Rules of conduct	483.10(b)(1)	(1) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under section 1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing;	O.C.G.A. § 31-8-112(c) (Alcohol and tobacco use must be permitted unless otherwise provided in admission agreement) Appendix PP, 156 "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.
Access to Records	483.10(b)(2)	(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.	See O.C.G.A. § 31-8-106(e) (access to non-medical records) Ga. R. & Regs. 111-8-56.-11 42 C.F.R. 483.75(l), which identifies the clinical record set, provides that clinical records must be maintained so that they are readily accessible. Appendix PP, F153 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. ... In the absence of State statute, the "cost not to exceed the community standard" is that rate charged per copy by organizations

[2] Guardians and conservators have absolute power to exercise a resident's rights to the full extent of their appointment.
[3] Health agents and financial agents may exercise a resident's rights unless the resident objects.

			Notes and Cross References
			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.
Informed re health status	483.10(b)(3)	(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;	O.C.G.A. § 31-8-108(b)(6) Appendix PP, F154 – Links with 483.10(d)(3), F175, which covers the resident's right to plan care and treatment.
Right to refuse treatment	483.10(b)(4)	(4) The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section; and	O.C.G.A § 31-8-108(b)(3) (refuse treatment) O.C.G.A. § 31-8-108(c) (refuse experimental treatment) Any refusal of treatment must be documented in the plan of care. See § 483.20(k). Appendix PP, F155 As provided under State law, a resident who has the capacity to make a health care decision and who withholds consent to treatment or makes an explicit refusal of treatment either directly or through an advance directive, may not be treated against his/her wishes.... If the resident is unable to make a health care decision, a decision by the resident's surrogate or representative to forego treatment may, subject to State law, be equally binding on the facility. ... A resident's refusal of treatment does not absolve a facility from providing a resident with care that allows him/her to attain or maintain his/her highest practicable physical, mental and psychosocial well-being in the context of making that refusal. Links with 483.10(b)(8), F156
Medicaid benefits	483.10(b)(5)	(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	Appendix PP: Residents should be told in advance when changes will occur in their bills. Providers must fully inform the resident of services and related changes. "Periodically" means that whenever changes are being introduced that will affect the residents liability and whenever there are changes in services.

			Notes and Cross References
		services specified in paragraphs (5)(i) (A) and (B) of this section.	
Services and charges	483.10(b)(6)	(6) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.	See O.C.G.A. § 31-8-106(a)(1) and (a)(2); (b) Appendix PP: A Medicare beneficiary who requires services upon admission that are not covered under Medicare may be required to submit a deposit provided the notice provisions of §483.10(b)(6), if applicable, are met.
Legal rights	483.10(b)(7)	(7) The facility must furnish a written description of legal rights which includes— (i) A description of the manner of protecting personal funds, under paragraph (c) of this section; (ii) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels; (iii) A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and (iv) A statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.	See O.C.G.A. § 31-8-104 Appendix PP, F156
Advance directives	483.10(b)(8)	(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,	42 C.F.R. § 489.102 Appendix PP: The facility is not required to provide care that conflicts with an advance directive. In addition, the facility is not required to implement an advance directive if, as a matter of conscience, the provider cannot implement an advance directive and State law allows the provider to

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			formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. If an adult individual is incapacitated at the time of admission and is unable to receive information (due to the incapacitating condition or a mental disorder) or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated individual or to a surrogate or other concerned persons in accordance with State law. The facility is not relieved of its obligation to provide this information to the individual once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.	conscientiously object. (See §483.10(b)(4), F155.)
Contacting physician	483.10(b)(9)	(9) The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.	O.C.G.A. § 31-8-108(b)(4) Appendix PP: "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.)
How to apply for Medicaid	483.10 (b)(10)	(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	Appendix PP: Nursing facilities are not responsible for orally providing detailed information about Medicare and Medicaid eligibility rules.

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		Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.	**"**Refunds for previous payments" refers to refunds due as a result of Medicaid and Medicare payments when eligibility has been determined retroactively.
Change in condition	483.10 (b)(11)	(11) *Notification of changes.* (i) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal respresentative 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: 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. O.C.G.A. § 31-8-108(b)(5) (change in condition)
Distinct part: Admission agreement	483.10 (b)(12)	(12) *Admission to a composite distinct part.* A facility that is a composite distinct part (as defined in § 483.5(c) of this subpart) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under § 483.12(a)(8).	
Protection of Funds	483.10(c)	(c) *Protection of resident funds.*	
Right to manage	483.10(c)(1)	(1) The resident has the right to manage his or her	O.C.G.A. § 31-8-115(b)

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funds		financial affairs, and the facility may not require residents to deposit their personal funds with the facility.	Appendix PP, F158
Management of personal funds	483.10(c)(2)	(2) *Management of personal funds.* Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.	O.C.G.A. § 31-8-115(b) Appendix PP, F159 "Hold, safeguard, manage and account for" means that the facility must act as fiduciary of the resident's funds and report at least quarterly on the status of these funds in a clear and understandable manner.
Deposit of funds	483.10(c)(3)	(3) *Deposit of funds.* (i) *Funds in excess of $50*. The facility must deposit any residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) (ii) *Funds less than $50*. The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund.	Appendix PP, F159
Accounting and records	483.10(c)(4)	(4) *Accounting and records.* The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (i) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (ii) The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.	
Notice of balances	483.10(c)(5)	(5) *Notice of certain balances.* The facility must notify each resident that receives Medicaid benefits— (i) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and (ii) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.	

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Conveyance upon death	483.10(c)(6)	(6) *Conveyance upon death.* Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.	Appendix PP, F160
Assurance of financial security	483.10(c)(7)	(7) *Assurance of financial security*. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.	Appendix PP, F161
Limitation on personal charges	483.10(c)(8)	(8) *Limitation on charges to personal funds.* The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts). The facility may charge the resident for requested services that are more expensive than or in excess of covered services in accordance with § 489.32 of this chapter. (This does not affect the prohibition on facility charges for items and services for which Medicaid has paid. See § 447.15, which limits participation in the Medicaid program to providers who accept, as payment in full, Medicaid payment plus any deductible, coinsurance, or copayment required by the plan to be paid by the individual.)	Appendix PP, F162
Services included in Medicare or Medicaid	483.10(c)(8)(i)	(i) *Services included in Medicare or Medicaid payment.* During the course of a covered Medicare or Medicaid stay, facilities may not charge a resident for the following categories of items and services: (A) Nursing services as required at § 483.30 of this subpart. (B) Dietary services as required at § 483.35 of this subpart. (C) An activities program as required at § 483.15(f) of this subpart. (D) Room/bed maintenance services. (E) Routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture	

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		cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing, and basic personal laundry. (F) Medically-related social services as required at § 483.15(g) of this subpart.	
Services excluded from Medicare or Medicaid	483.10(c)(8)(ii)	(ii) *Items and services that may be charged to residents' funds.* Listed below are general categories and examples of items and services that the facility may charge to residents' funds if they are requested by a resident, if the facility informs the resident that there will be a charge, and if payment is not made by Medicare or Medicaid: (A) Telephone. (B) Television/radio for personal use. (C) Personal comfort items, including smoking materials, notions and novelties, and confections. (D) Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare. (E) Personal clothing. (F) Personal reading matter. (G) Gifts purchased on behalf of a resident. (H) Flowers and plants. (I) Social events and entertainment offered outside the scope of the activities program, provided under § 483.15(f) of this subpart. (J) Noncovered special care services such as privately hired nurses or aides. (K) Private room, except when therapeutically required (for example, isolation for infection control). (L) Specially prepared or alternative food requested instead of the food generally prepared by the facility, as required by § 483.35 of this subpart. (iii) *Requests for items and services.* (A) The facility must not charge a resident (or his or her representative) for any item or service not requested by the resident. (B) The facility must not require a resident (or his or her representative) to request any item or service as a condition of admission or continued stay. (C) The facility must inform the resident (or his or her representative) requesting an item or service for which a charge will be made that there will be a charge for the item or service and what the charge will be.	Appendix PP: The facility may not charge the resident's account for specially prepared foods that are required by the physician's order of a therapeutic diet. A facility may not charge a resident or the resident's representative for items and services that are not requested by the resident or representative, whether or not the item or services is requested by a physician. The item or service ordered by the physician should fit in with the resident's care plan.

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Free Choice	483.10(d)	(d) *Free choice.* The resident has the right to— (1) Choose a personal attending physician; (2) Be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being; and (3) Unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, participate in planning care and treatment or changes in care and treatment.	42 U.S.C. § 1396r(b)(2)(B); § 1396r(c)(1)(A)(i) 42 U.S.C. § 1395i-3(b)(2)(B) O.C.G.A. § 31-8-108(b)(1) (choose physician) Appendix PP, F163: A facility may not place barriers in the way of residents choosing their own physicians. O.C.G.A. § 31-8-108(b)(2) (participate in care plan) O.C.G.A. § 31-8-112(b)(rise and retire at times of resident's choice)
Privacy and Confidentiality	483.10(e)	(e) *Privacy and confidentiality*. The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. (1) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident; (2) Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility; (3) The resident's right to refuse release of personal and clinical records does not apply when— (i) The resident is transferred to another health care institution; or (ii) Record release is required by law.	O.C.G.A. § 31-8-111(3) O.C.G.A. § 31-8-114 42 C.F.R. 483.75(l) (clinical records); see also §§ 483.10(i), (j) and (k); § 483.70(d)(1)(iv). Appendix PP, F164: "Right to privacy" means that the resident has the right to privacy with whomever the resident wishes to be private and that this privacy should include full visual, and, to the extent desired, for visits or other activities, auditory privacy
Grievances	483.10(f)	(f) *Grievances.* A resident has the right to— (1) Voice grievances without discrimination or reprisal. Such grievances include those with respect to treatment which has been furnished as well as that which has not been furnished; and (2) Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.	See O.C.G.A. § 31-8-104 O.C.G.A. § 31-8-124 Appendix PP, F165, F166
Examination of Survey Results	483.10(g)	(g) *Examination of survey results.* A resident has the right to— (1) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination in a place	Ga. R. & Regs. 111-8-56.-01(w) (plan of improvement) Appendix PP, F167, F168

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		readily accessible to residents, and must post a notice of their availability; and (2) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.	
Work	483.10(h)	(h) *Work.* The resident has the right to— (1) Refuse to perform services for the facility; (2) Perform services for the facility, if he or she chooses, when— (i) The facility has documented the need or desire for work in the plan of care; (ii) The plan specifies the nature of the services performed and whether the services are voluntary or paid; (iii) Compensation for paid services is at or above prevailing rates; and (iv) The resident agrees to the work arrangement described in the plan of care.	O.C.G.A. § 31-8-112(1) Appendix PP, F169
Mail	483.10(i)	(i) *Mail.* The resident has the right to privacy in written communications, including the right to— (1) Send and promptly receive mail that is unopened; and (2) Have access to stationery, postage, and writing implements at the resident's own expense.	Appendix PP, F170, F171
Access and visitation rights	483.10(j)	(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	O.C.G.A. § 31-8-120 O.C.G.A. § 31-8-112(d)(resident permitted to enter and leave) 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

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		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.	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. Appendix PP, F173, Ombudsman access to records
Telephone	483.10(k)	(k) *Telephone.* The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard	Appendix PP, F174
Personal Property	483.10(l)	(l) *Personal property*. The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.	O.C.G.A. § 31-8-113(a) Appendix PP indicates the purpose of this regulation is to encourage residents to bring items into the nursing home
Married couples	483.10(m)	(m) *Married couples.* The resident has the right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement.	O.C.G.A. § 31-8-116(f) Appendix PP, F175. See also § 483.15(b)(3)
Self-administration of drugs	483.10(n)	(n) *Self-Administration of Drugs.* An individual resident may self-administer drugs if the interdisciplinary team, as defined by § 483.20(d)(2)(ii), has determined that this practice is safe.	Ga. R. & Regs. 111-8-56.-10(7)(d) Appendix PP, F176 If a resident requests to self-administer drugs, it is the responsibility of the interdisciplinary team to determine that it is safe for the resident to self-administer drugs before the resident may exercise that right.
Refusal of certain transfers	483.10(o)	(o) *Refusal of certain transfers.* (1) An individual has the right to refuse a transfer to another room within the institution, if the purpose of the transfer is to relocate— (i) A resident of a SNF from the distinct part of the institution that is a SNF to a part of the institution that is not a SNF, or (ii) A resident of a NF from the distinct part of the institution that is a NF to a distinct part of the institution that is a SNF. (2) A resident's exercise of the right to refuse transfer under paragraph (o)(1) of this section does not affect the individual's eligibility or entitlement to Medicare or Medicaid benefits.	Appendix PP, F177
Transfer and Discharge: Defined	483.12(a)(1)	(1) *Definition:* Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within	Appendix PP "Transfer" is moving the resident from the facility to another legally responsible institutional setting, while "discharge" is moving the resident to a non-institutional setting when the releasing facility ceases to be

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		the same certified facility.	responsible for the resident's care.
Transfer and discharge requirements	483.12(a)(2)	(2) *Transfer and discharge requirements.* The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless— (i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (ii) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (iii) The safety of individuals in the facility is endangered; (iv) The health of individuals in the facility would otherwise be endangered; (v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (vi) The facility ceases to operate.	O.C.G.A. § 31-8-116(a) Ga. R. & Regs. 111-8-56.-05(4) (shall transfer patients who require care not provided)
Documentation	483.12(a)(3)	(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.	Appendix PP: To demonstrate that any of the events specified in 1 - 5 have occurred, the law requires documentation in the resident's clinical record. To demonstrate situations 1 and 2, the resident's physician must provide the documentation. In situation 4, the documentation must be provided by any physician.
Notice before transfer	483.12(a)(4)	(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.	
Timing of notice	483.12(a)(5)	(5) *Timing of the notice.* (i) Except as specified in	O.C.G.A. § 31-8-116(d)

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			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.	
	Contents of notice	483.12(a)(6)	(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.	
	Orientation for transfer or discharge	483.12(a)(7)	(7) *Orientation for transfer or discharge.* A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.	
	Notice of facility	483.12(a)(8)	(8) *Notice in advance of facility closure.* In the case	

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closure		of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the Secretary, the State LTC ombudsman, residents of the facility, and the legal representatives of the residents or other responsible parties, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.75(r).	
Room changes	483.12(a)(9)	(9) *Room changes in a composite distinct part.* Room changes in a facility that is a composite distinct part (as defined in § 483.5(c)) must be limited to moves within the particular building in which the resident resides, unless the resident voluntarily agrees to move to another of the composite distinct part's locations.	
Notice of bed-hold and readmission	483.12(b)	(8) *Notice in advance of facility closure.* In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the Secretary, the State LTC ombudsman, residents of the facility, and the legal representatives of the residents or other responsible parties, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.75(r).	Appendix PP: The nursing facility's bed-hold policies apply to all residents.
Equal access to quality health care	483.12(c)	(c) *Equal access to quality care.* (1) A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all individuals regardless of source of payment; (2) The facility may charge any amount for services furnished to non-Medicaid residents consistent with the notice requirement in § 483.10(b)(5)(i) and (b)(6) describing the charges; and (3) The State is not required to offer additional services on behalf of a resident other than services provided in the State plan.	The facility cannot charge fees in excess of those in its notice pursuant to 483.10(b)(5)(i) and (b)(6).
Admissions Policy	483.12(d)	(d) *Admissions policy*. (1) The facility must— (i) Not require residents or potential residents to waive their rights to Medicare or Medicaid; and (ii) Not require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits.	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

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			(2) The facility must not require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may require an individual who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources. (3) In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility. However,— (i) A nursing facility may charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the State plan as included in the term "nursing facility services" so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident's admission or continued stay on the request for and receipt of such additional services; and (ii) A nursing facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility for a Medicaid eligible resident. (4) States or political subdivisions may apply stricter admissions standards under State or local laws than are specified in this section, to prohibit discrimination against individuals entitled to Medicaid.	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. O.C.G.A. § 31-8-119
Restraints	483.13(a)	(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.		42 U.S.C. § 1396r(c)(1)(A)(ii) O.C.G.A § 31-8-109 Ga. R. & Regs. 111-8-56.-10(9)

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			Appendix PP: The intent of this requirement is for each person to attain and maintain his/her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints. 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. [T]he legal surrogate or representative cannot give permission to use restraints for the sake of discipline or staff convenience or when the restraint is not necessary to treat the resident's medical symptoms. That is, the facility may not use restraints in violation of the regulation solely based on a legal surrogate or representative's request or approval.
Abuse	483.13(b)	(b) *Abuse.* The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.	
Staff treatment of residents	483.13(c)	(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	Appendix PP: No State can override the obligation of the nursing home to fulfill the requirements under §483.13(c), so long as the Medicare/Medicaid certification is in place.

			Notes and Cross References
		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.	
Dignity	483.15(a)	(a) *Dignity*. The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	Appendix PP: "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.
Self-determination	483.15(b)	(b) *Self-determination and participation*. The resident has the right to— (1) Choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; (2) Interact with members of the community both inside and outside the facility; and (3) Make choices about aspects of his or her life in the facility that are significant to the resident.	
Participation in resident and family groups	483.15(c)	(c) *Participation in resident and family groups.* (1) A resident has the right to organize and participate in resident groups in the facility; (2) A resident's family has the right to meet in the facility with the families of other residents in the facility; (3) The facility must provide a resident or family group, if one exists, with private space; (4) Staff or visitors may attend meetings at the group's invitation; (5) The facility must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings; (6) When a resident or family group exists, the	O.C.G.A. 31-8-111(4) O.C.G.A. § 31-8-121 (family council)

			Notes and Cross References
		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.	
Participation in other activities	483.15(d)	(d) *Participation in other activities.* A resident has the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.	O.C.G.A. § 31-8-111(2) O.C.G.A. 31-8-111(4) Ga. R. & Regs. 111-8-56.-01(i)
Accommodation of needs	483.15(e)	(e) *Accommodation of needs.* A resident has the right to— (1) Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered; and (2) Receive notice before the resident's room or roommate in the facility is changed.	Appendix PP: "Reasonable accommodations of individual needs and preferences," means the facility's efforts to individualize the resident's physical environment. ... The facility is responsible for evaluating each resident's unique needs and preferences and ensuring that the environment accommodates the resident to the extent reasonable and does not endanger the health or safety of individuals or other residents. This includes making adaptations of the resident's bedroom and bathroom furniture and fixtures, as necessary.
Activities	483.15(f)	(f) *Activities.* (1) The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. (2) The activities program must be directed by a qualified professional who— (i) Is a qualified therapeutic recreation specialist or an activities professional who— (A) Is licensed or registered, if applicable, by the State in which practicing; and (B) Is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or (ii) Has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or (iii) Is a qualified occupational therapist or occupational therapy assistant; or (iv) Has completed a training course approved by the State.	Ga. R. & Regs. 111-8-56.-01(i) Ga. R. & Regs. 111-8-56.-16 Appendix PP: The intent of this requirement is that: • The facility identifies each resident's interests and needs; and • The facility involves the resident in an ongoing program of activities that is designed to appeal to his or her interests and to enhance the resident's highest practicable level of physical, mental, and psychosocial well-being.
Social Services	483.15(g)	(g) *Social Services.* (1) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. (2) A	42 U.S.C. § 1396r(b)(7) Ga. R. & Regs. 111-8-56.-07 Ga. R. & Regs. 111-8-56.-01(r) ("full-time employee")

			Notes and Cross References
		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.	
Environment	483.15(h)	(h) *Environment.* The facility must provide— (1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible; (2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; (3) Clean bed and bath linens that are in good condition; (4) Private closet space in each resident room, as specified in § 483.70(d)(2)(iv) of this part; (5) Adequate and comfortable lighting levels in all areas; (6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71-81°F; and (7) For the maintenance of comfortable sound levels.	Ga. R. & Regs. 111-8-56.-13

Medicaid Summary

Medicaid benefits	483.10(b)(5)	
Legal rights	483.10(b)(7)(ii)	
How to apply for Medicaid	483.10 (b)(10)	
Balances	483.10(c)(5)	
Limitation on charges	483.10(c)(8)	
Services included	483.10(c)(8)(i)	
Services excluded	483.10(c)(8)(ii)	
Refusal of certain transfers	483.10(o)	

Transfer and discharge requirements	483.12(a)(2)	
Equal access to quality health care	483.12(c)	
Admissions Policy	483.12(d)	

Health

			Notes and Cross References
Assessment	483.20	The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity.	
Admission Orders	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.	Ga. R. & Regs. 111-8-56.-010(1) and (2)
Comprehensive Assessment	483.20(b)	(b) *Comprehensive assessments*—(1) *Resident assessment instrument.* A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: (i) Identification and demographic information. (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychosocial well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnoses and health conditions. (xi) Dental and nutritional status. (xii) Skin condition. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge potential. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process	42 U.S.C. § 1396r(b)(3)(A) 42 U.S.C. § 1395i-3(b)(3)(A)

				Notes and Cross References
			must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. (2) *When required.* Subject to the timeframes prescribed in § 413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2) (i) through (iii) of this section. The timeframes prescribed in § 413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.) (ii) Within 14 calendar days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purposes of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) (iii) Not less often than once every 12 months.	Within 14 days of admission; within 14 days following significant change in condition and not less often than once every 12 months. 42 U.S.C. § 1396r(b)(3)(C)(i) 42 U.S.C. § 1395i-3(b)(3)(C)(i)
Quarterly review assessment	483.20(c)	(c) *Quarterly review assessment.* A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.	42 U.S.C. § 1396r(b)(3)(C)(ii) 42 U.S.C. § 1395i-3(b)(3)(C)(ii)
Use	483.20(d)	(d) *Use.* A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review, and revise the resident's comprehensive plan f care.	42 U.S.C. § 1396r(b)(3)(D) 42 U.S.C. § 1396i-3(b)(3)(D)
Coordination	483.20(e)	(e) *Coordination.* A facility must coordinate assessments with the preadmission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort.	42 U.S.C. § 1396r(b)(3)(B) 42 U.S.C. § 1396r(b)(3)(E)

				Notes and Cross References
	Automated data processing	483.20(f)	(f) *Automated data processing requirement*—(1) *Encoding data.* Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. (2) *Transmitting data.* Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. (3) *Transmittal requirements.* Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i) Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment. (4) *Data format.* The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. (5) *Resident-identifiable information.* (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.	
	Accuracy of	483.20(g)	(g) *Accuracy of assessments.* The assessment must	42 U.S.C. § 1396r(b)(3)(A)

			Notes and Cross References
assessments		accurately reflect the resident's status.	
Coordination	483.20(h)	(h) *Coordination.* A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.	
Certification	483.20(i)	(i) *Certification.* (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	42 U.S.C. § 1396r(b)(3)(B)
Penalty for falsification	483.20(j)	(j) *Penalty for falsification.* (1) Under Medicare and Medicaid, an individual who willfully and knowingly— (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement.	
Comprehensive care plans	483.20(k)	(k) *Comprehensive care plans.* (1) The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following— (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under § 483.25; and (ii) Any services that would otherwise be required under § 483.25 but are not provided due to the resident's exercise of rights under § 483.10, including the right to refuse treatment under § 483.10(b)(4). (2) A comprehensive care plan must be— (i) Developed within 7 days after completion of the comprehensive assessment; (ii) Prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal	42 U.S.C. § 1396r(b)(2) 42 U.S.C. § 1395i-3(b)(2) Ga. R. & Regs. 111-8-56.-01(h) 42 U.S.C. § 1396r(b)(2)(B) 42 U.S.C. § 1395i-3(b)(2)(B)

				Notes and Cross References
			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.	42 U.S.C. § 1396r(b)(2)(C) 42 U.S.C. § 1395i-3(b)(2)(C)
	Discharge summary	483.20(l)	(l) *Discharge summary*. When the facility anticipates discharge a resident must have a discharge summary that includes— (1) A recapitulation of the resident's stay; (2) A final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative; and (3) A post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.	
	Preadmission screening for mentally ill individuals	483.20(m)	(m) *Preadmission screening for mentally ill individuals and individuals with mental retardation.* (1) A nursing facility must not admit, on or after January 1, 1989, any new resident with— (i) Mental illness as defined in paragraph (f)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Mental retardation, as defined in paragraph (f)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission— (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. (2) *Definition.* For purposes of this	PASRR; 42 C.F.R. § 483.100 through 483.138 42 U.S.C. § 1396r(b)(3)(F)

				Notes and Cross References
			section— (i) An individual is considered to have *mental illness* if the individual has a serious mental illness as defined in § 483.102(b)(1). (ii) An individual is considered to be *mentally retarded* if the individual is mentally retarded as defined in § 483.102(b)(3) or is a person with a related condition as described in 42 CFR 435.1010 of this chapter.	

				Notes and Cross References
Overview: Quality of Care	42 CFR 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.	42 U.S.C. § 1396r(b)(2) 42 U.S.C. § 1395i-3(b)(2) 42 U.S.C. § 1396r(b)(4) 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.
ADLs		483.25(a)	***Activities of daily living.*** Based on the comprehensive assessment of a resident, the facility must ensure that— **(1)** A resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to— **(i)** Bathe, dress, and groom; **(ii)** Transfer and ambulate; **(iii)** Toilet; **(iv)** Eat; and **(v)** Use speech, language, or other functional communication systems. **(2)** A resident is given the appropriate treatment and services to maintain or improve his or her	The key word is “unavoidable.” The resident'c condition should not decline unless it is clinically unavoidable. This requires documentation.

			Notes and Cross References
		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.	
Vision/hearing	483.25(b)	***Vision and hearing.*** To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident— **(1)** In making appointments, and **(2)** By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices	This regulation requires assistance in making arrangements for care outside the facility.
Pressure Ulcers	483.25(c)	***Pressure sores.*** Based on the comprehensive assessment of a resident, the facility must ensure that— **(1)** A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and **(2)** A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing	Avoidable pressure ulcers should not develop.
Incontinent/UTI	483.25(d)	***Urinary Incontinence.*** Based on the resident's comprehensive assessment, the facility must ensure that— **(1)** A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and **(2)** A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible	
Range of motion	483.25(e)	***Range of motion.*** Based on the comprehensive assessment of a resident, the facility must ensure that— **(1)** A resident who enters the facility without a limited range of motion does not experience	

			Notes and Cross References
		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	
Mental/ Pyschosocial	483.25(f)	***Mental and Psychosocial functioning.*** Based on the comprehensive assessment of a resident, the facility must ensure that— **(1)** A resident who displays mental or psychosocial adjustment difficulty, receives appropriate treatment and services to correct the assessed problem, and **(2)** A resident whose assessment did not reveal a mental or psychosocial adjustment difficulty does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that such a pattern was unavoidable	
Nasogastric	483.25(g)	***Naso-gastric tubes.*** Based on the comprehensive assessment of a resident, the facility must ensure that— **(1)** A resident who has been able to eat enough alone or with assistance is not fed by naso-gastric tube unless the resident's clinical condition demonstrates that use of a naso-gastric tube was unavoidable; and **(2)** A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills	
Accidents	483.25(h)	***Accidents.*** The facility must ensure that— **(1)** The resident environment remains as free of accident hazards as is possible; and **(2)** Each resident receives adequate supervision and assistance devices to prevent accidents	
Nutrition	483.25(i)	***Nutrition.*** Based on a resident's comprehensive assessment, the facility must ensure that a resident—	

			Notes and Cross References
		(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	
Hydration	483.25(j)	***Hydration.*** The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health	
Special Needs	483.25(k)	***Special needs.*** The facility must ensure that residents receive proper treatment and care for the following special services: **(1)** Injections; **(2)** Parenteral and enteral fluids; **(3)** Colostomy, ureterostomy, or ileostomy care; **(4)** Tracheostomy care; **(5)** Tracheal suctioning; **(6)** Respiratory care; **(7)** Foot care; and **(8)** Prostheses	
Unnecessary Drugs	483.25(l)	***Unnecessary drugs—*** **(1)** ***General.*** Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: **(i)** In excessive dose (including duplicate drug therapy); or **(ii)** For excessive duration; or **(iii)** Without adequate monitoring; or **(iv)** Without adequate indications for its use; or **(v)** In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or **(vi)** Any combinations of the reasons above. **(2)** ***Antipsychotic Drugs.*** Based on a comprehensive assessment of a resident, the facility must ensure that— **(i)** Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and **(ii)** Residents who use antipsychotic drugs receive gradual dose reductions, and behavioral	Ga. R. & Regs. 111-8-56.-10(6)(a)

			Notes and Cross References
		interventions, unless clinically contraindicated, in an effort to discontinue these drug	
Medication errors	483.25 (m)	***Medication Errors.*** The facility must ensure that— **(1)** It is free of medication error rates of five percent or greater; and **(2)** Residents are free of any significant medication errors	
Immunizations	483.25(n)	***Influenza and pneumococcal immunizations—*** **(1)** ***Influenza.*** The facility must develop policies and procedures that ensure that— **(i)** Before offering the influenza immunization, each resident or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; **(ii)** Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; **(iii)** The resident or the resident's legal representative has the opportunity to refuse immunization; and **(iv)** The resident's medical record includes documentation that indicates, at a minimum, the following: **(A)** That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and **(B)** That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. **(2)** ***Pneumococcal disease.*** The facility must develop policies and procedures that ensure that— **(i)** Before offering the pneumococcal immunization, each resident or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; **(ii)** Each resident is offered a pneumococcal	Ga. R. & Regs. 111-8-56.-27

			Notes and Cross References
		immunization, unless the immunization is medically contraindicated or the resident has already been immunized; **(iii)** The resident or the resident's legal representative has the opportunity to refuse immunization; and **(iv)** The resident's medical record includes documentation that indicates, at a minimum, the following: **(A)** That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and **(B)** That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. **(v)** ***Exception.*** As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.	
Nursing services	483.30	The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.	
Sufficient staff	483.30(a)	(a) *Sufficient staff.* (1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (c) of this section, licensed nurses; and (ii) Other nursing personnel. (2) Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.	42 C.F.R. § 483.75(g) (staff necessary to provide services; qualified staff) Ga. R. & Regs. 111-8-56.-04(5) (minimum of 2.0 hours of direct nursing care per patient in a 24 hour period) Ga. R. & Regs. 111-8-56.-04(7) (sufficient supervisory personnel)
Registered nurse	483.30(b)	(b) *Registered nurse.* (1) Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse	Ga. R. & Regs. 111-8-56.-01(o) Ga. R. & Regs. 111-8-56.-04

			Notes and Cross References
		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.	
Nursing facilities	483.30(c)	(c) *Nursing facilities: Waiver of requirement to provide licensed nurses on a 24-hour basis.* To the extent that a facility is unable to meet the requirements of paragraphs (a)(2) and (b)(1) of this section, a State may waive such requirements with respect to the facility if— (1) The facility demonstrates to the satisfaction of the State that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities), to recruit appropriate personnel; (2) The State determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility; (3) The State finds that, for any periods in which licensed nursing services are not available, a registered nurse or a physician is obligated to respond immediately to telephone calls from the facility; (4) A waiver granted under the conditions listed in paragraph (c) of this section is subject to annual State review; (5) In granting or renewing a waiver, a facility may be required by the State to use other qualified, licensed personnel; (6) The State agency granting a waiver of such requirements provides notice of the waiver to the State long term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965) and the protection and advocacy system in the State for the mentally ill and mentally retarded; and (7) The nursing facility that is granted such a waiver by a State notifies residents of the facility (or, where appropriate, the guardians or legal representatives of such residents) and members of their immediate families of the waiver.	
SNF waiver of 40 hour week	483.30(d)	(d) *SNFs: Waiver of the requirement to provide services of a registered nurse for more than 40*	Ga. R. & Regs. 111-8-56.-01(r) (“full-time employee”)

			Notes and Cross References
requirement		*hours a week*. (1) The Secretary may waive the requirement that a SNF provide the services of a registered nurse for more than 40 hours a week, including a director of nursing specified in paragraph (b) of this section, if the Secretary finds that— (i) The facility is located in a rural area and the supply of skilled nursing facility services in the area is not sufficient to meet the needs of individuals residing in the area; (ii) The facility has one full-time registered nurse who is regularly on duty at the facility 40 hours a week; and (iii) The facility either— (A) Has only patients whose physicians have indicated (through physicians' orders or admission notes) that they do not require the services of a registered nurse or a physician for a 48-hours period, or (B) Has made arrangements for a registered nurse or a physician to spend time at the facility, as determined necessary by the physician, to provide necessary skilled nursing services on days when the regular full-time registered nurse is not on duty; (iv) The Secretary provides notice of the waiver to the State long term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965) and the protection and advocacy system in the State for the mentally ill and mentally retarded; and (v) The facility that is granted such a waiver notifies residents of the facility (or, where appropriate, the guardians or legal representatives of such residents) and members of their immediate families of the waiver. (2) A waiver of the registered nurse requirement under paragraph (d)(1) of this section is subject to annual renewal by the Secretary.	
Nurse staffing information	483.30(e)	(e) *Nurse staffing information*—(1) *Data requirements.* The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State	42 U.S.C. § 1396r(b)(8)

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		law). (C) Certified nurse aides. (iv) Resident census. (2) *Posting requirements.* (i) The facility must post the nurse staffing data specified in paragraph (e)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) *Public access to posted nurse staffing data.* The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) *Facility data retention requirements.* The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	
Dietary services	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.	Ga. R. & Regs. 111-8-56.-06
Staffing	483.35(a)	(a) *Staffing.* The facility must employ a qualified dietitian either full-time, part-time, or on a consultant basis. (1) If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food service who receives frequently scheduled consultation from a qualified dietitian. (2) A qualified dietitian is one who is qualified based upon either registration by the Commission on Dietetic Registration of the American Dietetic Association, or on the basis of education, training, or experience in identification of dietary needs, planning, and implementation of dietary programs.	42 C.F.R. § 483.75(g) Ga. R. & Regs. 111-8-56.-01(r) (“full-time employee”)
Sufficient staff	483.35(b)	(b) *Sufficient staff.* The facility must employ sufficient support personnel competent to carry out the functions of the dietary service.	42 C.F.R. § 483.75(g) (staff necessary to provide services; qualified staff)
Menus and nutritional adequacy	483.35(c)	(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.	

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Food	483.35(d)	(d) *Food.* Each resident receives and the facility provides— (1) Food prepared by methods that conserve nutritive value, flavor, and appearance; (2) Food that is palatable, attractive, and at the proper temperature; (3) Food prepared in a form designed to meet individual needs; and (4) Substitutes offered of similar nutritive value to residents who refuse food served.	
Therapeutic diets	483.35(e)	(e) *Therapeutic diets.* Therapeutic diets must be prescribed by the attending physician.	
Frequency of meals	483.35(f)	(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.	
Assistive devices	483.35(g)	(g) *Assistive devices.* The facility must provide special eating equipment and utensils for residents who need them.	
Paid feeding assistants	483.35(h)	(h) *Paid feeding assistants*—(1) *State-approved training course.* A facility may use a paid feeding assistant, as defined in § 488.301 of this chapter, if— (i) The feeding assistant has successfully completed a State-approved training course that meets the requirements of § 483.160 before feeding residents; and (ii) The use of feeding assistants is consistent with State law. (2) *Supervision.* (i) A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). (ii) In an emergency, a feeding assistant must call a supervisory nurse for help on the resident call system. (3) *Resident selection criteria.* (i) A facility must ensure that a feeding assistant feeds only residents who have no complicated feeding problems. (ii) Complicated feeding problems include, but are not limited to,	Ga. R. & Regs. 111-8-56.-01(aa) Ga. R. & Regs. 111-8-56.-25

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		difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings. (iii) The facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care.	
Sanitary conditions	483.35(i)	(i) *Sanitary conditions.* The facility must— (1) Procure food from sources approved or considered satisfactory by Federal, State, or local authorities; (2) Store, prepare, distribute, and serve food under sanitary conditions; and (3) Dispose of garbage and refuse properly.	
Physician services	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.	Ga. R. & Regs. 111-8-56.-01(k) Ga. R. & Regs. 111-8-56.-05(2)
Physician supervision	483.40(a)	(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.	42 U.S.C. § 1396r(b)(6)(A)
Physician visits	483.40(b)	(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.	Ga. R. & Regs. 111-8-56.-05(3)
Frequency of physician visits	483.40(c)	(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	Ga. R. & Regs. 111-8-56.-05(3)

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		accordance with paragraph (e) of this section.	
Availability of physicians for emergency care	483.40(d)	(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.	42 U.S.C. § 1396r(b)(6)(B)
Physician delegation of tasks in SNFs	483.40(e)	(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.	
Performance of physician task in NFs	483.40(f)	(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.	
Rehabilitation Services: Provision of services	483.45(a)	(a) *Provision of services.* If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must— (1) Provide the required services; or (2) Obtain the required services from an outside resource (in accordance with § 483.75(h) of this part) from a provider of specialized rehabilitative services.	
Qualifications	483.45(b)	(b) *Qualifications.* Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel.	
Dental services	483.55	The facility must assist residents in obtaining routine and 24-hour emergency dental care.	

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Skilled nursing facilities	483.55(a)	(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.	
Nursing facilities	483.55(b)	(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	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.	O.C.G.A. § 31-8-110 (Right to select pharmacy)
Procedures	483.60(a)	(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.	
Service consultation	483.60(b)	(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	Ga. R. & Regs. 111-8-56.-01(m)

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		an account of all controlled drugs is maintained and periodically reconciled.	
Drug regimen review	483.60(c)	(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.	
Labeling of drugs and biologicals	483.60(d)	(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.	
Storage of drugs and biologicals	483.60(e)	(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.	
Infection control	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.	Ga. R. & Regs. 111-8-56.-10
Infection control program	483.65(a)	(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.	
Preventing spread of	483.65(b)	(b) *Preventing spread of infection.* (1) When the infection control program determines that a	

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infection		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.	
Linens	483.65(c)	(c) *Linens.* Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	

Care Plan Summary

Physical Environment and Administration

			Notes and Cross References
Physical environment	483.70	The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public.	
Life safety from fire	483.70(a)	**(a)*Life safety from fire.*** **(1)** Except as otherwise provided in this section— **(i)** The facility must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101 ® 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-	

			Notes and Cross References
		6030, or go to: Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the *Federal Register* to announce the changes. **(ii)** Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the LSC does not apply to long-term care facilities. **(2)** After consideration of State survey agency findings, CMS may waive specific provisions of the Life Safety Code which, if rigidly applied, would result in unreasonable hardship upon the facility, but only if the waiver does not adversely affect the health and safety of 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)** Beginning March 13, 2006, a long-term care facility must be in compliance with Chapter 19.2.9, Emergency Lighting. **(5)** Beginning March 13, 2006, Chapter 19.3.6.3.2, exception number 2 does not apply to long-term care facilities. **(6)** Notwithstanding any provisions of the 2000 edition of the Life Safety Code to the contrary, a long-term care facility may install alcohol-based hand rub dispensers in its facility if— **(i)** Use of alcohol-based hand rub dispensers does not conflict with any State or local codes that prohibit or otherwise restrict the placement of alcohol-based hand rub dispensers in health care facilities; **(ii)** The dispensers are installed in a manner that minimizes leaks and spills that could lead to falls; **(iii)** The dispensers are installed in a manner that adequately protects against inappropriate access; **(iv)** The dispensers are installed in accordance with chapter 18.3.2.7 or chapter 19.3.2.7 of the	

			Notes and Cross References
		2000 edition of the Life Safety Code, as amended by NFPA Temporary Interim Amendment 00-1(101), issued by the Standards Council of the National Fire Protection Association on April 15, 2004. The Director of the Office of the Federal Register has approved NFPA Temporary Interim Amendment 00-1(101) for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the amendment is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD and at the Office of the Federal Register, 800 North Capitol Street NW., Suite 700, Washington, DC. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269; and **(v)** The dispensers are maintained in accordance with dispenser manufacturer guidelines. **(7)** 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*. **(8)** 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	

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		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 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 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.	
Emergency power	483.70(b)	**(b)*Emergency power.*** **(1)** An emergency electrical power system must supply power adequate at least for lighting all	

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		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.	
Space and equipment	483.70(c)	**(c)*Space and equipment.*** The facility must— **(1)** Provide sufficient space and equipment in dining, health services, recreation, and program areas to enable staff to provide residents with needed services as required by these standards and as identified in each resident's plan of care; and **(2)** Maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.	
Resident rooms	483.70(d)	**(d)*Resident rooms.*** Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents. **(1)** Bedrooms must— **(i)** Accommodate no more than four residents; **(ii)** Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms; **(iii)** Have direct access to an exit corridor; **(iv)** Be designed or equipped to assure full visual privacy for each resident; **(v)** In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains; **(vi)** Have at least one window to the outside; and **(vii)** Have a floor at or above grade level. **(2)** The facility must provide each resident with— **(i)** A separate bed of proper size and height for the convenience of the resident; **(ii)** A clean, comfortable mattress; **(iii)** Bedding appropriate to the weather and climate; and **(iv)** Functional furniture appropriate to the	

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		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.	
Toilet facilities	483.70(e)	**(e)*Toilet facilities.*** Each resident room must be equipped with or located near toilet and bathing facilities.	
Resident call system	483.70(f)	**(f)*Resident call system.*** The nurse's station must be equipped to receive resident calls through a communication system from— **(1)** Resident rooms; and **(2)** Toilet and bathing facilities.	
Dining and resident activities	483.70(g)	**(g)*Dining and resident activities.*** The facility must provide one or more rooms designated for resident dining and activities. These rooms must— **(1)** Be well lighted; **(2)** Be well ventilated, with nonsmoking areas identified; **(3)** Be adequately furnished; and **(4)** Have sufficient space to accommodate all activities.	
Other environmental conditions	483.70(h)	**(h)*Other environmental conditions.*** The facility must provide a safe, functional, sanitary, and comfortable environment for the residents, staff and the public. The facility must— **(1)** Establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply; **(2)** Have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two; **(3)** Equip corridors with firmly secured handrails on each side; and **(4)** Maintain an effective pest control program so	

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		that the facility is free of pests and rodents.	
Administration	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.	
Licensure	483.75(a)	**(a)*Licensure.*** A facility must be licensed under applicable State and local law.	
Compliance with laws	483.75(b)	**(b)*Compliance with Federal, State, and local laws and professional standards.*** The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.	
Relationship with other regulations	483.75(c)	**(c)*Relationship to other HHS regulations.*** In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of handicap (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455). Although these regulations are not in themselves considered requirements under this part, their violation may result in the termination or suspension of, or the refusal to grant or continue payment with Federal funds.	
Governing body	483.75(d)	**(d)*Governing body.*** **(1)** The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and **(2)** The governing body appoints the administrator who is— **(i)** Licensed by the State where licensing is required; and **(ii)** Responsible for management of the facility.	Ga. R. & Regs. 111-8-56.-01(s) (governing body) Ga. R. & Regs. 111-8-56.-02 Ga. R. & Regs. 111-8-56.-01(t) (Administrator) Ga. R. & Regs. 111-8-56.-02(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.”) Ga. R. & Regs. 111-8-56.-03

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Required training of CNAs	483.75(e)	**(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	42 U.S.C. § 1396r(b)(5) 42 C.F.R. § 483.150 through 483.160 Ga. R. & Regs. 111-8-56.-01(r) (“full-time employee”) Ga. R. & Regs. 111-8-56.-04(9) (training)

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		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	

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		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.	
Proficiency of CNAs	483.75(f)	**(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.	42 C.F.R. § 483.154
Staff qualifications	483.75(g)	**(g)*Staff qualifications.*** **(1)** The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. **(2)** Professional staff must be licensed, certified, or registered in accordance with applicable State laws.	
Use of outside resources	483.75(h)	**(h)*Use of outside resources.*** **(1)** If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or (with respect to services furnished to NF residents and dental services furnished to SNF residents) an agreement described in paragraph (h)(2) of this section. **(2)** Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for— **(i)** Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and **(ii)** The timeliness of the services.	
Medical director	483.75(i)	**(i)*Medical director.*** **(1)** The facility must designate a physician to serve as medical director. **(2)** The medical director is responsible for— **(i)** Implementation of resident care policies; and **(ii)** The coordination of medical care in the facility.	Ga. R. & Regs. 111-8-56.-05(1)

			Notes and Cross References
Laboratory services		**(j)*Laboratory services.*** **(1)** The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. **(i)** If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. **(ii)** If the facility provides blood bank and transfusion services, it must meet the applicable requirements for laboratories specified in part 493 of this chapter. **(iii)** If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of services in accordance with the requirements of part 493 of this chapter. **(iv)** If the facility does not provide laboratory services on site, it must have an agreement to obtain these services from a laboratory that meets the applicable requirements of part 493 of this chapter. **(2)** The facility must— **(i)** Provide or obtain laboratory services only when ordered by the attending physician; **(ii)** Promptly notify the attending physican of the findings; **(iii)** Assist the resident in making transportation arrangements to and from the source of service, if the resident needs asistance; and **(iv)** File in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory.	
Radiology and other diagnostic services	483.75(k)	**(k)*Radiology and other diagnostic services.*** **(1)** The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. **(i)** If the facility provides its own diagnostic services, the services must meet the applicable	

			Notes and Cross References
		conditions of participation for hospitals contained in § 482.26 of this subchapter. **(ii)** If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare. **(2)** The facility must— **(i)** Provide or obtain radiology and other diagnostic services only when ordered by the attending physician; **(ii)** Promptly notify the attending physician of the findings; **(iii)** Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance; and **(iv)** File in the resident's clinical record signed and dated reports of x-ray and other diagnostic services.	
Clinical records	483.75(l)	**(l)*Clinical records.*** **(1)** The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are— **(i)** Complete; **(ii)** Accurately documented; **(iii)** Readily accessible; and **(iv)** Systematically organized. **(2)** Clinical records must be retained for— **(i)** The period of time required by State law; or **(ii)** Five years from the date of discharge when there is no requirement in State law; or **(iii)** For a minor, three years after a resident reaches legal age under State law. **(3)** The facility must safeguard clinical record information against loss, destruction, or unauthorized use; **(4)** The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is required by— **(i)** Transfer to another health care institution; **(ii)** Law; **(iii)** Third party payment contract; or	42 C.F.R. § 483.10(e) 42 U.S.C. § 1396r(b)(6)(C) Ga. R. & Regs. 111-8-56.-11 Appendix PP: "Keep confidential" is defined as safeguarding the content of information including video, audio, or other computer stored information from unauthorized disclosure without the consent of the individual and/or the individual's surrogate or representative.

			Notes and Cross References
		(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.	
Disaster and emergency preparedness	483.75(m)	**(m)*Disaster and emergency preparedness.*** **(1)** The facility must have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents. **(2)** The facility must train all employees in emergency procedures when they begin to work in the facility, periodically review the procedures with existing staff, and carry out unannounced staff drills using those procedures.	
Transfer agreement	483.75(n)	**(n)*Transfer agreement.*** **(1)** In accordance with section 1861(l) of the Act, the facility (other than a nursing facility which is located in a State on an Indian reservation) must have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably assures that— **(i)** Residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician; and **(ii)** Medical and other information needed for care and treatment of residents, and, when the transferring facility deems it appropriate, for determining whether such residents can be adequately cared for in a less expensive setting than either the facility or the hospital, will be exchanged between the institutions. **(2)** The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible.	42 U.S.C. § 1395i-3(a)(2) 42 U.S.C. § 1396r(a)(2) Ga. R. & Regs. 111-8-56.-01(j)
Quality assessment	483.75(o)	**(o)*Quality assessment and assurance.***	42 U.S.C. § 1396r(b)(1)(B)

			Notes and Cross References
and assurance		**(1)** A facility must maintain a quality assessment and assurance committee consisting of— **(i)** The director of nursing services; **(ii)** A physician designated by the facility; and **(iii)** At least 3 other members of the facility's staff. **(2)** The quality assessment and assurance committee— **(i)** Meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and **(ii)** Develops and implements appropriate plans of action to correct identified quality deficiencies. **(3)** A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. **(4)** Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	42 U.S.C. § 1395i-3(b)(1)(B)
Disclosure of ownership	483.75(p)	**(p)*Disclosure of ownership.*** **(1)** The facility must comply with the disclosure requirements of §§ 420.206 and 455.104 of this chapter. **(2)** The facility must provide written notice to the State agency responsible for licensing the facility at the time of change, if a change occurs in— **(i)** Persons with an ownership or control interest, as defined in §§ 420.201 and 455.101 of this chapter; **(ii)** The officers, directors, agents, or managing employees; **(iii)** The corporation, association, or other company responsible for the management of the facility; or **(iv)** The facility's administrator or director of nursing. **(3)** The notice specified in paragraph (p)(2) of this section must include the identity of each new individual or company.	
Required training of feeding assistants	483.75(q)	**(q)*Required training of feeding assistants.*** A facility must not use any individual working in the facility as a paid feeding assistant unless that	

			Notes and Cross References
		individual has successfully completed a State-approved training program for feeding assistants, as specified in § 483.160 of this part.	
Facility closure - Administrator	483.75(r)	**(r)*Facility closure-Administrator.*** Any individual who is the administrator of the facility must: **(1)** Submit to the Secretary, the State LTC ombudsman, residents of the facility, and the legal representatives of such residents or other responsible parties, written notification of an impending closure: **(i)** At least 60 days prior to the date of closure; or **(ii)** In the case of a facility where the Secretary or a State terminates the facility's participation in the Medicare and/or Medicaid programs, not later than the date that the Secretary determines appropriate; **(2)** Ensure that the facility does not admit any new residents on or after the date on which such written notification is submitted; and **(3)** Include in the notice the plan for the transfer and adequate relocation of the residents of the facility by a date that would be specified by the State prior to closure, including assurances that the residents would be transferred to the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs, choice, and best interests of each resident.	
Facility closure	483.75(s)	**(s)*Facility closure.*** The facility must have in place policies and procedures to ensure that the administrator's duties and responsibilities involve providing the appropriate notices in the event of a facility closure, as required at paragraph (r) of this section.	