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MEMORANDUM

DATE: April 25, 2016

TO: Ms. Kimberly Xavier, DMMA
Planning, Policy and Quality Unit
DM-P/ARR

FROM: Daniese McMullin-Powell, Chairperson
State Council for Persons with Disabilities

RE: 19 DE Reg. 888 [DMMA Proposed Medicaid LTC "Bed Hold" Payment Regulation (4/1/16)

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Health and Social Services/Division of Medicaid and Medical Assistance's (DMMAs) proposal to amend its Medicaid "bed hold" standards applicable to long-term care facilities. The proposed regulation was published as 19 DE Reg. 888 in the April 1, 2016 issue of the Register of Regulations.

As background, a CMS regulation (42 CFR §447.40) allows states, at state option, to make "bed hold" payments to a long-term care facility during a resident's temporary absence due to hospitalization or other specified reasons. DMMA currently implements this option but plans to modify it for residents of an ICF/IID. In a nutshell, the normal paid 7-day bed-hold period per hospitalization would be extended to 14 days for Delaware's only ICF/IIDs - Stockley Center and Mary Campbell Center. The expected fiscal impact for FFY17 is $25,000 in State funds and $29,585 in federal funds.

SCPD endorses the extended paid "bed-hold" period for ICF/IIDs but has the following observations and recommendations.

First, on p. 889, the reference to 42 CFR §440.40 is incorrect. The reference should be to 42 CFR §447.40.

Second, consistent with 42 CFR §447.40, DMMA reaffirms the current policy of allowing up to 18 days per calendar year of "bed-hold" payments if included in the resident's plan of care. It would be informative to include the following clarifying sentence after Par. "2" on p. 891: "This may include absences included in a plan of care due to transfers to a 'specialized treatment

facility' consistent with Title 16 Del.C. §1121(18)." This would be instructive to providers and residents seeking to reconcile Medicaid payment standards and the overlapping State "bed -hold" statute. For similar reasons, the same sentence could be added to §20650.2.1 on p. 892.

Third, waiver of the 18 day paid leave of absence limit can be obtained if the LTC facility applies and its medical director confirms medical necessity. This may be unduly limiting. It would be preferable to allow either the LTC facility or the resident [supported by his personal attending physician [16 Del.C. §1121(21)] to apply for a waiver since a resident's view may be different than the facility's view. CMS recognizes the divergence of interest in the context of transfers and discharges. See 42 C.F.R. §483.12(a)(3)(i); attached CMS Surveyor Guidance F201-203; and attached CMS proposed regulations, 80 Fed Reg. 42247-42249, 42254-42255. For example, the facility may prefer that the resident or resident's family "private pay" for the period in excess of 18 days since that results in higher payment.

Thank you for your consideration and please contact SCPD if you have any questions or comments regarding our observations or recommendations on the proposed regulation.

cc: Mr. Stephen Groff, DMMA
Ms. Jill Rogers, DDDS
Ms. Sheila Grant, AARP
Mr. Brian Hartman, Esq.
The Arc of Delaware
Down Syndrome Association of Delaware
Governor's Advisory Council for Exceptional Citizens
Developmental Disabilities Council

19reg888 dmma-medicaid ltc bed hold payment 4-19-16

EXCERPT

State Operations Manual
Appendix PP - Guidance to Surveyors for Long Term Care Facilities
Table of Contents

(Rev. 149, 10-09-15)

Transmittals for Appendix PP

INDEX

hospitalization or therapeutic leave, and whose absence exceeds the bed-hold period as defined by the State plan, to return to the facility in the first available bed. (See §483.12(b).)

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

§483.10(o), Tag F177, addresses the right of residents to refuse certain transfers within an institution on the basis of payment status.

F201

§483.12(a)(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 nursing facility, the nursing facility may charge a resident only allowable charges under Medicaid; or

(vi) The facility ceases to operate.

SEE GUIDANCE UNDER TAG 202

F202
(Rev. 127, Issued: 11-26-14, Effective: 11-26-14, Implementation: 11-26-14)

§483.12(a)(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.

Interpretive Guidelines:§483.12(a)(2) and (3)

If transfer is due to a significant change in the resident's condition, but not an emergency requiring an immediate transfer, then prior to any action, the facility must conduct the appropriate assessment to determine if a new care plan would allow the facility to meet the resident's needs. (See §483.20(b)(4)(iv), F274, for information concerning assessment upon significant change.)

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

Refusal of treatment would not constitute grounds for transfer, unless the facility is unable to meet the needs of the resident or protect the health and safety of others.

Documentation of the transfer/discharge may be completed by a physician extender unless prohibited by State law or facility policy.

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

Procedures:§483.12(a)(2) and (3)

During closed record review, determine the reasons for transfer/discharge.

If the entity to which the resident was discharged is another long term care facility, evaluate the extent to which the discharge summary and the resident's physician justify why the facility could not meet the needs of this resident.

Probes: §483.12(a)(2) and (3)

Do records document accurate assessments and attempts through care planning to address resident's needs through multi-disciplinary interventions, accommodation of individual needs and attention to the resident's customary routines?

Did the resident's physician document the record if:

- The resident was transferred/discharged for the sake of the resident's welfare and the resident's needs could not be met in the facility (e.g., a resident develops an acute condition requiring hospitalization)? or

- The resident's health improved to the extent that the transferred/discharged resident no longer needed the services of the facility.

Did a physician document the record if residents were transferred because the health of individuals in the facility is endangered?

Do the records of residents transferred/discharged due to safety reasons reflect the process by which the facility concluded that in each instance transfer or discharge was necessary? Did the survey team observe residents with similar safety concerns in the facility? If so, determine differences between these residents and those who were transferred or discharged.

Look for changes in source of payment coinciding with transfer. If you find such transfer, determine if the transfers were triggered by one of the criteria specified in §483.12(a)(2).

- Ask the ombudsman if there were any complaints regarding transfer and/or discharge. If there were, what was the result of the ombudsman's investigation?

F203
(Rev. 107, Issued: 04-04-14, Effective: 04-04-14, Implementation: 04-04-14)

§483.12(a)(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.

§483.12(a)(5) Timing of the notice.

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

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

or money without the resident's consent.

Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or mental illness.

Nurse aide. A nurse aide is any individual providing nursing or nursing-related services to residents in a facility. This term may also include an individual who provides these services through an agency or under a contract with the facility, but 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.

Person-centered care. For purposes of this subpart, person-centered care means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives.

Resident representative. For purposes of this subpart, the term resident representative means an individual of the resident's choice who has access to information and participates in healthcare discussions or a personal representative with legal standing, such as a power of attorney, legal guardian, or health care surrogate appointed or designated in accordance with state law. If selected as the resident representative, the same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated.

Sexual abuse is non-consensual sexual contact of any type with a resident.

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

■ 13. Section 483.10 is revised to read as follows:

§ 483.10 Resident rights.

The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.

(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 and to be supported by the facility in the exercise of his or her rights as required under this subpart.

(3) A resident has the right to designate a representative, in accordance with State law.

(i) The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the resident representative. .

(ii) The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law.

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

(i) The resident may exercise his or her rights to the extent not prohibited by court order.

(ii) The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law.

(iii) The resident's wishes and preferences must be considered in the exercise of rights by the representative.

(iv) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process.

(5) 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. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated.

(b) *Planning and implementing care.* The resident has the right to be informed of, and participate in, his or her treatment, including:

(1) 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.

(2) The right to be informed, in advance, of the care to be furnished and the disciplines that will furnish care.

(3) The right to be informed in advance of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.

(4) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive as specified in § 483.11(e)(6).

(5) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:

(i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.

(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.

(iii) The right to be informed, in advance, of changes to the plan of care.

(iv) The right to receive the services and/or items included in the plan of care.

(v) The right to see the care plan, including the right to sign after changes to the plan of care.

(6) The right to self-administer medications if the interdisciplinary team has determined that this practice is clinically appropriate in accordance with § 483.11(b)(2).

(7) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.

(c) *Choice of attending physician.* The resident has the right to choose his or her attending physician.

(1) The physician must be licensed to practice, and

(2) The physician must meet the professional credentialing requirements of the facility.

(3) If the physician chosen by the resident refuses to or does not meet requirements specified in this part, the facility may seek alternate physician participation as specified in § 483.11(c) to assure provision of appropriate and adequate care and treatment.

(d) *Respect and dignity.* The resident has a right to be treated with respect and dignity, including:

(1) 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.

(2) The right to retain and use personal possessions, including furnishings, and clothing, as space

permits, unless to do so would infringe upon the rights or health and safety of other residents.

(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.

(4) 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.

(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement.

(6) The right to receive notice before the resident's room or roommate in the facility is changed.

(7) The right to refuse to transfer to another room in the facility, 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.

(8) A resident's exercise of the right to refuse transfer does not affect the resident's eligibility or entitlement to Medicare or Medicaid benefits.

(e) *Self-determination.* The resident has the right to self-determination, including but not limited to the right to—

(1) Choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care;

(2) Interact with members of the community and participate in community activities both inside and outside the facility;

(3) Receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation, and in a manner that does not impose on the rights of another resident, including the individuals specified in § 483.11(d);

(4) Organize and participate in resident groups in the facility;

(5) Participate in family groups;

(6) Have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility;

(7) Participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility;

(8) Choose to or refuse to perform services for the facility subject to the facility requirements in § 483.11(d)(4);

(9) Manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds as specified in § 483.11(d)(6)(ii);

(10) Make choices about aspects of his or her life in the facility that are significant to the resident.

(f) *Access to information.* (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility.

(2) The resident has the right to receive notices verbally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including

(i) Required notices as specified in § 483.11(e);

(ii) Information and contact information for State and local advocacy organizations, including but not limited to the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2006 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 *et seq.*);

(iii) Information regarding Medicare and Medicaid eligibility and coverage;

(iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program

(v) Contact information for the Medicaid fraud control unit; and

(vi) Information and contact information for filing grievances or complaints about abuse, neglect, misappropriation of resident property in the facility, and non-compliance with § 489.102 of this chapter.

(3) The resident has the right to access medical records pertaining to him or herself,—

(i) Upon an oral or written request, in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format when such medical records are maintained electronically); or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, including current medical records, within 24 hours (excluding weekends and holidays); and

(ii) After receipt of his or her medical records for inspection, to purchase, a copy of the medical records or any portions thereof (including in an electronic form or format when such medical records are maintained electronically) upon request and 2 working days advance notice to the facility. The facility may impose a reasonable, cost-based fee on the provision of copies, provided that the fee includes only the cost of:

(A) Labor for copying the medical records requested by the individual, whether in paper or electronic form;

(B) Supplies for creating the paper copy or electronic media if the individual requests that the electronic copy be provided on portable media; and

(C) Postage, when the individual has requested the copy be mailed.

(4) The resident has the right to—

(i) 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; and

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

(g) *Privacy and confidentiality.* The resident has a right to personal privacy and confidentiality of his or her personal and medical records.

(1) This includes the right to privacy in his or her verbal (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.

(2) 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;

(3) The resident has a right to a secure and confidential medical record.

(4) The resident has the right to refuse the release of personal and medical records except as provided at § 483.70(i)(2) or other applicable federal or state laws.

(h) *Communication.* (1) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense.

(2) The resident has the right to have reasonable access to and privacy in their use of electronic communications such

as email and video communications and for internet research.

(i) If the access is available to the facility.

(ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident.

(3) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to:

(i) Privacy of such communications consistent with paragraph (g)(1) of this section; and

(ii) Access to stationery, postage, and writing implements at the resident's own expense.

(i) *Safe environment.* The resident has a right to a safe, clean, comfortable and homelike environment in accordance with § 483.11(g), including but not limited to receiving treatment and supports for daily living safely.

(j) *Grievances.* (1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished.

(2) The resident has the right to prompt efforts by the facility to resolve grievances in accordance with § 483.11(h).

■ 14. Section 483.11 is added to subpart B to read as follows:

§ 483.11 Facility responsibilities.

A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident as specified in § 483.10, including, but not limited to the following obligations:

(a) *Exercise of rights.* (1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

(3) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law.

(4) The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law.

(5) If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility may report such concerns as permitted and shall report such concerns when and in the manner required under State law.

(b) *Planning and implementing care.* (1) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right, consistent with § 483.10(b). The planning process must:

(i) Facilitate the inclusion of the resident or resident representative.

(ii) Include an assessment of the resident's strengths and needs.

(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.

(2) The interdisciplinary team, as defined by § 483.21(b)(2)(ii), is responsible for determining if resident self-administration of medications is clinically appropriate.

(c) *Attending physician.* (1) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care.

(2) The facility must inform the resident if the facility determines that the physician chosen by the resident is unable or unwilling to meet requirements specified in this part and the facility seeks alternate physician participation to assure provision of appropriate and adequate care and treatment. The facility must discuss the alternative physician participation with the resident and honor the resident's preferences, if any, among options.

(3) If the resident subsequently selects another attending physician who meets the requirements specified in this part, the facility must honor that choice.

(d) *Self-determination.* The facility must promote and facilitate resident self-determination through support of resident choice as specified in § 483.10(e) and as follows:

(1) The facility must:

(i) Provide immediate access to any resident by:

(A) Any representative of the Secretary,

(B) Any representative of the State,

(C) Any representative of the Office of the State long term care ombudsman, (established under section 712 of the Older Americans Act of 1965, as amended 2006 (42 U.S.C. 3001 *et seq.*);

(D) The resident's individual physician,

(E) Any representative of the protection and advocacy systems, as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 *et seq.*),

(F) Any representative of the agency responsible for the protection and advocacy system for individuals with mental illness (established under the Protection and Advocacy for Mentally Ill Individuals Act of 2000 (42 U.S.C. 10802); and

(G) The resident representative.

(ii) Provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time;

(iii) Provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time;

(iv) Provide reasonable access to a 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; and

(2) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. A facility must meet the following requirements:

(i) Inform each resident (or resident representative, where appropriate) of his or her visitation rights, including any clinical or safety restriction or limitation on such rights, when he or she is informed of his or her other rights under this section.

(ii) Inform each resident of the right, subject to his or her consent, to receive the visitors whom he or she designates, including, but not limited to, a spouse (including a same-sex spouse), a domestic partner (including a same-sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time.

(iii) Not restrict, limit, or otherwise deny visitation privileges on the basis of

(B) Each covered individual shall report not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury.

(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act.

(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.

(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately to the administrator of the facility and to other officials (including to the State survey and certification agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

(2) Have evidence that all alleged violations are thoroughly investigated.

(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

(4) Report the results of all investigations to the administrator or his resident 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.

§ 483.13 [Removed]

■ 16. Remove § 483.13.

■ 17. Section 483.15 is revised to read as follows:

§ 483.15 Transitions of care.

Transitions of care include admissions to and discharges or transfers to or from a SNF or NF. This section also addresses bed-hold policies and therapeutic leave.

(a) *Admissions policy.* (1) The facility must establish and implement an admissions policy.

(2) The facility must—

(i) Not request or require residents or potential residents to waive their rights as set forth in this subpart and in applicable State, Federal or local licensing or certification laws, including but not limited to their rights to Medicare or Medicaid; and

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

(iii) Not request or require residents or potential residents to waive potential facility liability for losses of personal property

(3) The facility must not request or 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 request and require a resident representative 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.

(4) 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.

(5) 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.

(6) A nursing facility must disclose and provide to a resident or potential resident, at or prior to time of admission, notice of special characteristics or service limitations of the facility.

(7) A nursing facility that is a composite distinct part as defined in § 483.5(c) 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 paragraph (b)(10) of this section.

(b) *Transfer and discharge*—(1) *Facility requirements*—(i) *Equal access to quality care.* (A) A facility must establish, maintain and implement identical policies and practices regarding transfer, discharge, and the provision of services for all individuals regardless of source of payment;

(B) The facility may charge any amount for services furnished to non-Medicaid residents unless otherwise limited by state law and consistent with the notice requirement in § 483.11(e)(11)(i) and (e)(12) describing the charges; and

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

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

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

(B) 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;

(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;

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

(E) 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. Non-payment does not apply unless the resident does not submit the necessary paperwork for third party payment or until the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. 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

(F) The facility ceases to operate.

(iii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter..

(2) *Documentation.* When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (b)(1)(i)(A) through (F) of

this section, the facility must ensure that the transfer or discharge is documented in the resident's clinical record and appropriate information is communicated to the receiving health care institution or provider.

(i) Documentation in the resident's clinical record must include:

(A) The basis for the transfer per paragraph (b)(1)(ii).

(B) In the case of paragraph (b)(1)(ii)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).

(ii) The documentation must be made by—

(A) The resident's physician when transfer or discharge is necessary under paragraph (b)(1)(i)(A) or (B) of this section; and

(B) A physician when transfer or discharge is necessary under paragraph (b)(1)(i)(C) or (D) of this section.

(iii) Information provided to the receiving provider must include a minimum of the following:

(A) Demographic information including but not limited to name, sex, date of birth, race, ethnicity, and preferred language.

(B) Resident representative information including contact information.

(C) Advance Directive information.

(D) History of present illness/reason for transfer including primary care team contact information.

(E) Past medical/surgical history, including procedures.

(F) Active diagnoses/Current problem list and status.

(G) Laboratory tests and the results of pertinent laboratory and other diagnostic testing.

(H) Functional status.

(I) Psychosocial assessment, including cognitive status.

(J) Social Supports

(K) Behavioral Health Issues

(L) Medications.

(M) Allergies, including medication allergies.

(N) Immunizations.

(O) Smoking status.

(P) Vital signs.

(Q) Unique device identifier(s) for a patient's implantable device(s), if any.

(R) Comprehensive Care plan goals, including health concerns, assessment and plan, resident preferences, interventions, including efforts to meet resident needs, and resident status.

(iv) This requirement may be satisfied by the discharge summary providing it meets the requirements of § 483.21(c) and includes at a minimum the information specified in paragraph (b)(2)(iii) of this section.

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

(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. Subject to the resident's agreement, the facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.

(ii) Record the reasons for the transfer or discharge in the resident's clinical record in accordance with paragraph (b)(2) of this section; and

(iii) Include in the notice the items described in paragraph (b)(5) of this section.

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

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

(A) The safety of individuals in the facility would be endangered under paragraph (b)(1)(ii)(C) of this section;

(B) The health of individuals in the facility would be endangered, under paragraph (b)(1)(ii)(D) of this section;

(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (b)(1)(ii)(B) of this section;

(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (b)(1)(ii)(A) of this section; or

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

(5) *Contents of the notice.* The written notice specified in paragraph (b)(3) 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 expected to be transferred or discharged;

(iv) A statement that the resident has the right to appeal the action to the State, the name, address (mailing and email), and telephone number of the State entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;

(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;

(vi) For nursing facility residents with intellectual and developmental disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 10802); and

(vii) For nursing facility residents with mental illness, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with mental illness established under the Protection and Advocacy for Mentally Ill Individuals Act.

(6) *Changes to the notice.* If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

(7) *Orientation for transfer or discharge.* A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand.

(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 State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident 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 § 483.70(l).

(9) *Room changes in a composite distinct part.* Room changes in a facility that is a composite distinct part (as defined in § 483.5) are subject to the requirements of § 483.10(d)(7) and 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.

(c) *Notice of bed-hold policy and readmission*—(1) *Notice before transfer.* Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies—

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

(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;