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ARTICLES

**Advocating for Nursing Facility Residents
Under the Revised Federal Requirements**

By Eric Carlson, Esq., Lori Smetanka, Esq., and Nancy Stone, Esq

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Advocating for Nursing Facility Residents Under the Revised Federal Requirements

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I. Introduction

The Centers for Medicare & Medicaid Services (CMS) published a major revision of federal nursing facility regulations on October 4, 2016, providing new and expanded requirements for nursing facilities that participate in Medicare or Medicaid.¹ This was the first major revision since the regulations were issued more than 25 years before. This article provides a comprehensive guide to the revised regulations, focusing on care planning and person-centered care; admission, transfer, and discharge procedures; grievance procedures; resident rights, choice, safety, and self-determination; staffing, medications, and quality of care; and protections from abuse, neglect, and exploitation. The article also discusses advocacy and enforcement issues raised by the new rules

and subsequent CMS rulemaking activities under the administration of President Donald Trump, which are likely to result in modification of the rules.

A. History of Statute

Thirty years ago, through enactment of the Nursing Home Reform Act (NHRA), Congress approved sweeping reforms to improve nursing facility quality of care and establish resident rights.² The reform law applies to all nursing facilities (aka nursing homes) that accept payment from Medicare, Medicaid, or both. Congress enacted the landmark legislation in response to findings of the Institute of Medicine that despite federal regulations adopted in the 1970s, abuse and neglect were unfortunately common in nursing facilities across

1 81 Fed. Reg. 68688 (Oct. 4, 2016).

2 42 U.S.C. §§ 1395i-3 (Medicare), 1396r (Medicaid).

the country. In addition, quality of care in most nursing facilities left much to be desired and residents were often treated with disrespect and denied freedom of choice regarding activities, schedules, and other important aspects of life.³

B. Overview of Revisions

As CMS noted in the release of the revised regulations, the federal regulations had not been comprehensively reviewed and updated for a quarter of a century. Revisions were necessary to incorporate innovations and research-based knowledge in the areas of service delivery, individual choice, resident safety, health outcomes, professional standards, and quality assurance and performance improvement. CMS's stated goals in revising the regulations were to improve quality of care and quality of life and to optimize resident safety, while reducing procedural burdens on facility operators. The reforms included new and expanded requirements for the following:

- Person-centered care, assessment, and resident participation in care planning;
- Admission, transfer, and discharge procedures;
- Required services and quality improvement procedures;
- Facility grievance policy and grievance officials; and
- Protections from abuse, neglect, and exploitation.

The revised regulations also implement certain provisions of the 2010 Affordable Care Act, including the requirement for training on dementia care and abuse prevention and for reporting of suspicions of abuse. In addition, CMS extensively reor-

ganized and “re-designated” requirements in an effort to improve readability.⁴

Most of the revised regulations took effect on November 28, 2016 (Phase 1); however, the effective date of some new requirements was delayed until November 28, 2017 (Phase 2), or November 28, 2019 (Phase 3), to reduce the burden on nursing facilities of implementing the reforms.⁵ In addition, in 2017 CMS announced it will delay enforcement of certain Phase 2 requirements,⁶ as discussed in section III, and the regulation limiting arbitration agreements has been enjoined and likely will be rescinded by CMS.⁷

II. Guide to Revised Regulations

A. Admission

1. No Waiver of Legal Rights

Most residents admitted to nursing facilities are experiencing a decline in men-

3 Inst. of Med. Comm. on Nursing Home Reg., *Improving the Quality of Care in Nursing Homes*, <https://www.nap.edu/read/646/chapter/1> (1986) (accessed Dec. 28, 2017).

4 81 Fed. Reg. at 68825–68831, tbl. 1, tit. 42, cross-references to pt. 483, subpt. B; *see also* Natl. Consumer Voice for Quality Long-Term Care, *Side-by-Side Comparison of Revised Previous Federal Nursing Home Regulations*, <http://theconsumervoicet.org/uploads/files/issues/Side-by-Side-Comparison-of-Revised-and-Previous-Requirements-of-Participation-1-20-2017.pdf> (accessed Dec. 28, 2017).

5 81 Fed. Reg. at 68696–68698; *see also* Natl. Consumer Voice for Quality Long-Term Care, *Revised Federal Nursing Home Regulations, Implementation Timeframes*, http://theconsumervoicet.org/issues/issue_details/proposed-revisions-to-the-federal-nursing-home-regulations#Implementation-Timeframes (accessed Dec. 28, 2017).

6 Memo. from Ctrs. for Medicare & Medicaid Servs., Dir., Survey & Certification Group, to St. Survey Agency Dirs., *Revision to State Operations Manual (SOM) Appendix PP for Phase 2, F-Tag Revisions, and Related Issues*, <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-36.pdf> (June 30, 2017).

7 *See infra* at sections II.A.3 and III.

tal capacity resulting from Alzheimer's disease, other forms of dementia, or other ailments, compromising their ability to negotiate an admission agreement. It is an extremely stressful time for both residents and their families, who often are in crisis and will agree to almost anything to obtain access to needed health care services. Not surprisingly, admission agreements are typically drafted in terms more favorable to the facility than the resident.

Admission agreements frequently have misrepresented applicable laws.⁸ To address such problems, the NHRA prohibits facilities from requiring residents to waive their rights to Medicare and Medicaid. The revised regulations go further, prohibiting a facility not only from requiring, but even from asking, a resident to waive his or her rights under applicable local, state, and federal laws as well as Medicare and Medicaid. In addition, the terms of an admission agreement must not conflict with the regulations.⁹ Thus, under the revised regulations, surveyors (whose agencies survey (inspect) nursing facilities to ensure that they comply with the law) can cite a facility for using an admission agreement that requires a resident to waive rights under laws other than Medicare and Medicaid or otherwise conflicts with the requirements.¹⁰

In a similar vein, the revised regulations prohibit facilities from obtaining a waiver of liability for loss of a resident's personal property. Under the revised regulations, a facility must not "request or require residents or potential residents to waive po-

tential facility liability for losses of personal property."¹¹ In accord, the regulations also establish a facility duty to "exercise reasonable care for the protection of the resident's property from loss or theft."¹²

2. No Third-Party Guarantee of Payment

Under the NHRA, facilities are prohibited from requiring a third-party guarantee of payment as a condition of admission or continued residence. Despite the long-standing prohibition, arranging for a third party to take on financial liability continues to be a high priority for many nursing facilities.¹³

Some facilities, for example, have had a resident's relative or friend take on liability on the pretext that this person is volunteering to sign the admission agreement as guarantor. Under the revised regulations, however, a nursing facility can neither require nor request a third-party guarantee of payment.¹⁴

The NHRA does not prohibit a facility from requiring a resident's agent to sign an agreement to pay the facility's charges with the resident's assets. Under

11 42 C.F.R. § 483.15(a)(2)(iii).

12 *Id.* at § 483.10(i)(1)(ii).

13 For example, even though the state of California addressed this and other admission agreement issues by requiring nursing homes to use a Standard Admission Agreement (SAA), nursing homes could request modifications of the SAA if they could demonstrate unique circumstances. A 2014 study found that nursing homes most often requested modifications to the SAA that would require third parties to sign, add mandatory arbitration provisions, or reduce resident rights. Cal. Advoc. for Nursing Home Reform, *No Standards: How Nursing Homes Attempted to Undermine California's Standard Admission Agreement and Diminish Residents' Rights*, http://www.canhr.org/reports/2014/No_Standards_in_Nursing_Homes_Report.pdf (2014).

14 42 C.F.R. § 483.15(a)(3).

8 Eric Carlson, *Benefits for Consumers in the Revised Nursing Facility Regulations*, Natl. Ctr. on L. & Elder Rights Issue Br., <https://ncler.acl.gov/pdf/Benefits-for-Consumers-in-the-Revised-Nursing-Facility-Regulations.pdf> (Jan. 2017).

9 42 C.F.R. § 483.10(g)(10)(v).

10 Carlson, *supra* n. 8.

the revised regulations, the facility is authorized to 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.”¹⁵ The revised regulations, however, do not address a gambit that some facilities use: filing suit against a resident representative for allegedly violating his or her duty under the admission agreement to use the resident’s funds to pay the nursing facility bill and/or to take all necessary steps to obtain Medicaid eligibility on the resident’s behalf. For example, in *Sunrise Healthcare Corp. v. Azarigian*,¹⁶ the facility won a judgment for breach of contract against the resident’s daughter, and agent under a power of attorney, after Medicaid denied the resident’s application because of asset transfers the resident’s agent and then-deceased spouse made, including a substantial transfer by the spouse to a revocable trust.¹⁷ The court found that the defendant had breached the admission agreement by transferring assets for estate planning purposes and to pay for a personal companion for the resident, instead of using the funds to pay for the resident’s nursing facility costs and other “basic necessities.”¹⁸

Consumer advocates are sharply critical of the reasoning in *Sunrise* and similar cas-

es, because these types of lawsuits attempt to bypass both the prohibition against a third-party guarantee and the general rule that an agent is not liable for a principal’s debts. In many cases, rulings for the facility “likely are driven by the court’s lack of sympathy for the defendant, who may be a family member or friend who has misused the resident’s money rather than paying the facility for services rendered.”¹⁹ The issue of lawsuits against family members was brought to CMS’s attention, but CMS said that it needs “to further investigate this concern and consider it for future notice and comment rule-making.”²⁰

3. No Predispute Arbitration: Enjoined and New Rules Proposed

In the revised regulations, CMS prohibits the use of predispute arbitration agreements (i.e., arbitration agreements signed before a dispute arises). Generally, a predispute agreement is signed during the resident’s admission to a facility and applies to all disputes that subsequently arise between the resident and the facility. Unfortunately, however, CMS under President Trump likely will rescind the prohibition and further revise the rules for arbitration agreements.

Under the revised regulations, a facility must not enter into a predispute arbitration agreement with a resident or resident’s representative or require a resident to sign an arbitration agreement as a condition of admission. A facility may ask a resident to sign an arbitration agreement after a dispute arises, provided the facility complies with new requirements for drafting and entering into such an agreement.²¹

15 *Id.* at § 483.15(3).

16 821 A.2d 835 (Conn. App. 2003).

17 Amy Parise DeLaney, *Maneuvering the Labyrinth of Long-Term Care Admissions Contracts*, 4 NAELA J. 35 (2008); Edward E. Zetlin, *Relentless Pursuit: Claims Against Third Parties in Nursing Facility Collection Cases*, 1 NAELA J. 99 (2005), n. 1 (citing 56 Fed. Reg. 4881 (Sept. 26, 1991)).

18 *Sunrise*, *supra* n. 16.

19 Carlson, *supra* n. 8 (citing Eric M. Carlson, *Long-Term Care Advocacy* § 3.06[2][a] (Lexis-Nexis 1999)).

20 81 Fed. Reg. at 68688, 68732.

21 42 C.F.R. § 483.70(n).

The ban on predispute arbitration agreements was to take effect on November 28, 2016, but its implementation was enjoined by the U.S. District Court for the Northern District of Mississippi in *American Health Care Ass'n v. Burwell*,²² a lawsuit filed by a nursing facility trade association and a group of nursing facilities. The court found that the plaintiffs were likely to prevail on the theories that the prohibition conflicts with the Federal Arbitration Act and that CMS lacks statutory authority to adopt the prohibition.²³ CMS initially appealed the ruling to the Fifth Circuit; however, under the Trump administration, CMS moved to voluntarily dismiss the appeal. Further, CMS has issued proposed rules to reverse the ban on predispute arbitration agreements²⁴ (see section III for further discussion of this issue).

4. Notice of Service Limitations

In a new requirement, a facility must provide residents or potential residents with written notice of any special characteristics or service limitations.²⁵ The purpose of the notice requirement is to ensure informed choice by the resident and to prevent a resident's discharge or transfer

for an unanticipated inability of a facility to meet the resident's needs. Circumstances in which notice would be required include, for example, a facility:

- Whose practices are guided by a religious affiliation that results in special characteristics, requirements, or limitations; or
- That lacks the capability to care for residents requiring psychiatric care.²⁶

Any notice of service limitations should be carefully reviewed to determine if any service limitation is considered a denial of a service, or level of service, that nursing facilities must provide under the NHRA and the revised regulations.²⁷ This concern was brought to CMS's attention, but CMS did "not agree that providing this information allows or encourages providers to discriminate in the admissions process, nor does requiring it allow a facility to fail to provide required services."²⁸

B. Care Planning and Person-Centered Care

The revised regulations emphasize person-centered care — making the resident the center of control for decision-making about aspects of his or her daily life and supporting the resident in making his or her own choices.²⁹ This covers all areas of decision-making, including all aspects of planning and implementing care, establishing care goals and outcomes, mak-

22 217 F. Supp. 3d 921 (N.D. Miss. Nov. 7, 2016).

23 *Id.* at 929-39. The court said that plaintiffs relied on considerable statutory authority to support their claim that the prohibition conflicts with the Federal Arbitration Act (FAA), whereas CMS did not establish a strong factual basis for the prohibition in the administrative record and relied primarily on public comments, often from interested parties. The court also said that CMS might have harmonized the prohibition with the FAA by giving special attention to the issue of mental incompetency as a justification for distinguishing nursing home arbitration agreements.

24 82 Fed. Reg. 26649 (June 8, 2017).

25 42 C.F.R. § 483.15(a)(6).

26 80 Fed. Reg. 42167 (July 16, 2015).

27 Natl. Consumer Voice for Quality Long-Term Care, Ctr. for Medicare Advoc., & J. in Aging, *A Closer Look at the Revised Nursing Facility Regulations: Admission*, J. in Aging Issue Br., <http://www.justiceinaging.org/wp-content/uploads/2017/03/Revised-Nursing-Facility-Regulations-Admission.pdf> (accessed Dec. 28, 2017).

28 81 Fed. Reg. at 68688, 68731.

29 42 C.F.R. § 483.5.

ing informed choices about alternative treatments,³⁰ and retaining decision-making capability or delegating that ability to a representative.³¹ The regulations specifically call for residents with limited capacity to retain the ability to make decisions outside a representative's authority and for the resident's wishes and preferences to be considered by a representative exercising the resident's rights.³² Although the resident has always had the right to participate in care planning and decision-making, the regulations provide more clarity, with strong emphasis on a resident's autonomy.

The revised regulations include an important new requirement for facilities to develop an interim baseline care plan in addition to the resident's comprehensive care plan. The baseline care plan must be completed within 48 hours of admission.³³ This new provision is intended to ensure that all residents admitted to a nursing facility receive the appropriate medications, diet, therapies, and services from the start. Under the previous regulations, some residents have resided in facilities for up to 3 weeks without having a care plan.

The baseline care plan must include the basic health care information necessary to provide proper care for the resident, including initial goals based on admission, physician, and dietary orders; therapy services; and social services.³⁴ The resident and his or her representative must be given a summary of the baseline care plan that includes the resident's goals, medications, dietary instructions, and therapies or other services or treatments to be provided.³⁵

To ensure ongoing care coordination,

the regulations continue to require a comprehensive care plan³⁶ for each resident that includes measurable objectives and time frames to meet the resident's needs identified in the comprehensive assessment. The comprehensive assessment must be conducted using a CMS-specified resident assessment instrument and include a resident's needs, strengths, goals, life history, and preferences.³⁷ The assessment also must include information such as the resident's routine; patterns (cognitive, mood, and behavior); functional, communication, and visual abilities; activities; and continence.³⁸ The assessment is to be completed based on direct observation of the resident, along with communication with the resident and staff. The comprehensive assessment must be completed within 14 calendar days after admission, after significant change in the resident's physical or mental status, and at least annually.³⁹ A facility is also required to conduct a less-detailed quarterly assessment for each resident.⁴⁰

The comprehensive care plan, which must be developed within 7 days after the comprehensive assessment, must include the following:

- The services to be provided to attain or maintain the resident's highest practical physical, mental, and psychosocial well-being;⁴¹
- The resident's goals and desired outcomes;⁴²
- The resident's preference and potential for discharge;⁴³ and

30 *Id.* at § 483.10(c)(5).

31 *Id.* at § 483.10(b)(3).

32 *Id.* at § 483.10(b)(7).

33 *Id.* at § 483.21(a)(1)(i).

34 *Id.* at § 483.21(a).

35 *Id.* at § 483.21(a)(3).

36 *Id.* at § 483.21(b)(1).

37 *Id.* at § 483.20(b)(1).

38 *Id.*

39 *Id.* at § 483.21(b)(2).

40 *Id.* at § 483.21(c).

41 *Id.* at § 483.21(b)(1)(i).

42 *Id.* at § 483.21(b)(1)(iv)(A).

43 *Id.* at § 483.21(b)(1)(iv)(B).

- Discharge plans as appropriate.⁴⁴

Care plans must be developed through an interdisciplinary team directed by the resident or resident's representative. The revised regulations expand the composition of this team. The team must now include all those with responsibility for the resident, not only the attending physician and registered nurse but also a nurse aide, a food services staff member, and others as determined by the resident's needs or as requested by the resident.⁴⁵ The resident and his or her representative must be included in the development of the care plan to the extent possible. If such participation is determined not practicable, an explanation about why they were not included must be documented in the resident's medical record.⁴⁶ To make it easier to include residents and representatives in care planning, facilities should consider steps such as scheduling care plan meetings to fit a family member's schedule or including some team members via phone or video conference.

New in the revised regulations is a requirement that care plans be written with an eye toward cultural competency. The regulations also require care plans to be "trauma-informed," meaning that the care plan must take into account any ordeal or suffering the resident has experienced and determine appropriate interventions and services needed to lessen the trauma or prevent its exacerbation.⁴⁷

Also new is the requirement that care planning include discharge planning, unless the resident's file includes documentation that discharge planning is not desired.⁴⁸ A discharge plan must focus on the

resident's goals, include the resident as an active partner in the planning process, effectively prepare the resident for transition out of the facility, and reduce factors that could lead to preventable readmissions.⁴⁹ The interdisciplinary team must be involved in developing the discharge plan,⁵⁰ and the plan must take into account the availability of caregivers and/or other support people, including the resident's and the caregiver's/support person's capacity and capability to provide the required care.⁵¹

The discharge plan must be updated and revised as needed to reflect the resident's needs or goals.⁵² If the resident wants to return to the community, appropriate referrals to local contact agencies or other appropriate agencies must be made and documented. If it is determined that the resident cannot be discharged to the community, the facility must document who made the decision and why.⁵³

When the resident is ready for discharge, the facility must prepare a discharge summary of the resident's stay in the facility, including treatments, therapy, and test and consultation results; a summary of the resident's status based on a resident assessment; a reconciliation of all medications; and a post-discharge plan of care. The post-discharge plan must include where the individual will reside, arrangements for follow-up care, and needed medical and nonmedical services.⁵⁴

C. Resident Rights

1. Overview

Although CMS extensively reorganized, revised, and updated the regula-

44 *Id.* at § 483.21(b)(1)(iv)(C).

45 *Id.* at § 483.21(b)(2)(ii).

46 *Id.* at § 483.21(b)(2)(ii)(E).

47 *Id.* at § 483.21(b)(3).

48 *Id.* at § 483.21(c).

49 *Id.* at § 483.21(c)(1).

50 *Id.* at § 483.21(c)(1)(iii).

51 *Id.* at § 483.21(c)(1)(iv).

52 *Id.* at § 483.21(c)(1)(ii).

53 *Id.* at § 483.21(c)(1)(vii)(C).

54 *Id.* at § 483.21(c)(2).

tions, all NHRA-mandated resident rights are retained. CMS expanded certain requirements, particularly with respect to resident choice, safety, care planning participation, community interaction, and grievances.

2. Basic Rights

Under the revised regulations, “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” and “provide equal access to quality care regardless of diagnosis, severity of condition, or payment source.”⁵⁵ As in the previous regulations, facilities must not discriminate based on payment source (i.e., Medicaid) in transferring, discharging, and providing services to residents.⁵⁶

3. Exercising Rights

The NHRA protects the resident’s right to exercise his or her rights as a resident and U.S. citizen without interference, coercion, discrimination, or reprisal from the facility. The revised regulations echo this requirement, stating that the resident has the right to be supported by the facility in the exercise of his or her rights.⁵⁷

A resident has the right to designate a representative in accordance with state law, unless he or she has been adjudicated incompetent, and a resident representative may exercise the resident’s rights to the extent provided by state law. The revised regulations also protect the rights of a resident with a same-sex spouse, in

accordance with the U.S. Supreme Court decision in *United States v. Windsor*,⁵⁸ which invalidated the federal Defense of Marriage Act: “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.”⁵⁹

Responding to “concerns that resident representatives may be accorded more decision-making authority than their appointment or delegation permits,”⁶⁰ CMS added protections for resident rights with respect to the resident representative. A resident with a legal surrogate retains the right to make decisions that are outside a court-appointed representative’s authority or not delegated by the resident to the representative.⁶¹ Similarly, a facility must not extend to a resident’s representative the right to make decisions “beyond the extent required by the court or delegated by the resident.”⁶² Furthermore, if a facility has reason to believe that a resident’s representative is not acting in the resident’s best interest, the facility must report its concerns to state authorities as prescribed by state law.⁶³

4. Health Care Decision-Making

In a new subsection, CMS consolidated resident rights in the planning and implementation of health care services. Under these rights, a resident has the right to be informed of his or her treatment, health status, and medical condition in a language that he or she can understand; participate in care planning and

55 *Id.* at § 483.10(a)(1).

56 *Id.* at § 483.10(a)(2) (previously 42 C.F.R. § 483.12(c)).

57 *Id.* at § 483.10(b)(1)–(2).

58 80 Fed. Reg. at 42182 (citing 570 U.S. 12, 133 S. Ct. 2675 (2013)).

59 42 C.F.R. § 483.10(b)(3).

60 80 Fed. Reg. at 42181.

61 42 C.F.R. § 483.10(b)(7)(i).

62 *Id.* at § 483.10(b)(5).

63 *Id.* at § 483.10(b)(6).

treatment; request, refuse, or discontinue treatment; and formulate an advance directive.⁶⁴ CMS also added a requirement that the facility inform the resident of the right to participate in the care planning process and support the resident in exercising this right.⁶⁵

CMS emphasized that residents who are adjudicated incompetent also have the right to participate in care planning to the extent practicable,⁶⁶ commenting, “[I]t is important for a resident who has been adjudicated incompetent to be treated with respect and dignity and to continue to make those decisions that are appropriate for him or her to make.”⁶⁷

5. Choice of Attending Physician

The pre-existing resident right to choose an attending physician was relocated to a new subsection. Under the revised regulations, the facility must ensure that the attending physician is licensed and complies with the nursing facility requirements.⁶⁸ If the resident-selected physician does not meet the regulations, the facility may choose a physician for the resident, but only after discussing the matter with the resident and honoring the resident’s preference (if any) among options. The facility must ensure that the resident “remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care.”⁶⁹

6. Respect and Dignity: Restraints, Roommates, and Room Transfers

The NHRA prohibits the use of un-

necessary restraints. In accord, the revised regulations state that residents have a right to be treated with respect and dignity, including “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.”⁷⁰ In a new section of the regulations, unnecessary restraints are included in the definition of “abuse,” which is discussed further in section II(H). In the very rare circumstances in which restraints are medically indicated, the facility must ensure that residents are free from unnecessary restraints and “must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.”⁷¹

CMS revised the requirements regarding chemical restraints (i.e., behavior-modifying medications), commenting in the *Federal Register* that such medications too frequently are prescribed for residents to benefit the staff and not necessarily the resident’s health.⁷² This observation is supported by studies showing that behavior-modifying drugs are often used to sedate and control residents whose behavior is difficult for staff to manage, particularly residents with Alzheimer’s disease or other forms of dementia, and that nursing facilities with the largest percentage of residents receiving unnecessary antipsychotics tend to have the least amount of staff.⁷³ CMS extended the requirements regarding antipsychotic drugs to a larger class of psychotropic drugs and added provisions

64 *Id.* at § 483.10(c).

65 *Id.* at § 483.10(c)(3).

66 *Id.* at § 483.10(b)(7)(ii).

67 80 Fed. Reg. at 42182.

68 *Id.*

69 42 C.F.R. § 483.10(d)(3).

70 *Id.* at § 483.10(e)(1).

71 *Id.* at § 483.12(a)(2).

72 80 Fed. Reg. at 42240.

73 Breanna M. Taylor, *Drugging Grandma: The Severe Dangers of Chemically Restraining Nursing Home Residents With Potent Antipsychotic and Psychotropic Pharmaceuticals*, 24 *Elder L.J.* 213 (2016).

to reduce or eliminate the need for these medications.⁷⁴

Similar to the previous regulations, residents have the right to retain and use personal possessions as space permits, provided that doing so does not infringe upon other residents' health and safety.⁷⁵ In addition, residents have the "right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences,"⁷⁶ which emphasizes the facility's responsibility to accommodate resident choice and individuality.

Consenting spouses have always had the right to share a room in a facility; the rule applies to all married couples, whether opposite or same-sex.⁷⁷ The new regulations expand this right, specifying that a resident has the right to share a room with his or her "roommate of choice,"⁷⁸ in order to accommodate same-sex couples, siblings, other relatives, long-term friends, or any other choice of roommates.⁷⁹

The revised regulations retain a resident's right to refuse a transfer to another room, without affecting the resident's Medicare or Medicaid eligibility, if the relocation is intended to move the resident from a Medicare-certified room. The resident may also refuse to transfer to another room if the transfer is solely for staff convenience. Residents have a right to receive written notice of any change in room or roommate, including notice of the reason for the change.⁸⁰

7. Self-Determination; Visitation and Interaction With the Community

The self-determination rules emphasize resident choice in facility life and the facility's responsibility to promote, rather than obstruct, self-determination. Nursing facilities must promote, facilitate, and support resident choice in activities, schedules, visitation, and social, religious, and community activities. A resident has the right to choose schedules (including sleeping and waking times) and "to make choices about aspects of his or her life in the facility that are significant to the resident."⁸¹

In addition, residents have "a right to interact with members of the community and participate in community activities both inside and outside the facility."⁸² More specifically, the facility must provide activities that encourage interaction with the community⁸³ and support and accommodate resident participation in activities outside the facility "to the extent possible, including making transportation arrangements."⁸⁴ CMS commented when the revised regulations were released that some residents may not be able to participate in activities outside the facility but that many others may, especially with the support of family or other assistance and planning. In arranging for a resident's activities in the community, the facility must balance the resident's right to self-

74 See *infra* section II(F).

75 42 C.F.R. § 483.10(e)(2).

76 *Id.* at § 483.10(e)(3).

77 *Id.* at § 483.10(e)(4).

78 *Id.* at § 483.10(e)(5).

79 80 Fed. Reg. at 42182.

80 42 C.F.R. § 483.10(e)(6).

81 *Id.* at § 483.10(f)(1)–(2).

82 *Id.* at § 483.10(f)(3).

83 *Id.* at § 483.24(c).

84 Ctrs. for Medicare & Medicaid Servs., CMS Manual System, Publ. 100-7, State Operations Provider Certification, *SUBJECT: Revision to State Operations Manual (SOM) Appendix PP for Phase 2, F-Tag Revisions, and Related Issues 25*, http://theconsumervoice.org/uploads/files/issues/Revised_Interpretive_Guidelines_with_Clickable_TOC.pdf (effective Nov. 28, 2017).

determination with safety and security concerns.⁸⁵

CMS revised and clarified residents' rights to receive visitors and participate in family groups. Visitation rights are central: "The resident has the right to receive visitors of his or her choosing at the time of his or her choosing ... in a manner that does not impose on the rights of another resident."⁸⁶ The facility must provide prompt access to a resident by immediate family members, other relatives, and resident representatives, subject to the resident's desire to accept visits. Visits by persons other than family, however, are "subject to reasonable clinical and safety restrictions."⁸⁷ Advocates should be vigilant to ensure that safety restrictions are strictly interpreted. CMS's examples suggest that such strict interpretation is appropriate, stating that restrictions due to suspected abuse should be imposed until such suspicions are investigated or after an investigation confirms suspicions. CMS also refers to persons who are "inebriated or disruptive," suggesting that the label "disruptive" should not be extended broadly to persons the facility finds difficult.⁸⁸

Furthermore, CMS specifies that the facility must "ensure that all visitors enjoy full and equal visitation privileges consistent with resident preferences" and must not "restrict, limit, or otherwise deny visitation privileges on the basis of race, color,

national origin, religion, sex, gender identity, sexual orientation, or disability."⁸⁹

The facility also must provide "reasonable access" to a resident by an entity or individual who provides legal services.⁹⁰

The revised regulations clarify that a resident has the right to participate in resident groups and to have his or her family members or resident representatives meet in the facility with family groups.⁹¹

8. Information and Communication

Resident rights regarding access to information have been updated to incorporate advances in electronic medical records and communications. Residents have the right to "reasonable access to and privacy in their use of electronic communications such as email and video communications and for [i]nternet research."⁹² Residents have a right to reasonable access to and use of a telephone. New provisions specify that a resident has the right to retain and use a cell phone at the resident's expense. The nursing facility must protect and facilitate the resident's right to communicate with others, both inside and outside the facility, by providing reasonable access to communication devices, including the internet, to the extent available to the facility.⁹³

CMS clarified in the revised regulations that each resident has "the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands," commenting in the *Federal Register* that "effective communication for some residents requires the use of auxiliary aids and services."⁹⁴ Facilities have a responsibility

85 81 Fed. Reg. at 68718–68719.

86 42 C.F.R. § 483.10(f)(4).

87 *Id.* at § 483.10(f)(4)(ii)–(iii).

88 Ctrs. for Medicare & Medicaid Servs., surveyor's guideline on 42 C.F.R. § 483.10(f)(4)(iii)–(iv), in *State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities*, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf (Nov. 22, 2017).

89 42 C.F.R. § 483.10(f)(4)(vi)(C)(D).

90 *Id.* at § 483.10(f)(4)(iv).

91 *Id.* at § 483.10(f)(6)–(7).

92 *Id.* at § 483.10(g)(9).

93 *Id.* at § 483.10(g)(6)–(7).

94 *Id.* at § 483.10(g)(4); proposed rules Fed. Reg.

to provide notices to residents regarding their legal rights, Medicare and Medicaid eligibility, advance directives, protection of personal funds, facility policies, rules and regulations governing resident conduct and responsibilities at the facility, grievance procedures, and contact information for pertinent regulatory, informational, and advocacy agencies.

Residents have the right to access their medical records, and the facility must provide access, upon oral or written request “in the form or format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format, when such records are maintained electronically)...”⁹⁵ The facility may charge a reasonable, cost-based fee for providing copies of medical records, provided the fee includes only the cost of labor, supplies, and postage if mailed.⁹⁶

9. Privacy and Confidentiality

The resident’s right to privacy and confidentiality concerning his or her personal and medical records has been retained and updated to account for electronic communications. The facility must respect the resident’s right to privacy in his or her spoken, written, and electronic communications.⁹⁷ CMS commented that the rights granted in the revised regulations do not conflict with HIPAA privacy and security rules.⁹⁸

10. Safe Environment

CMS moved certain requirements for the residents’ environment to “Resident

Rights,” focusing on increasing resident safety and protecting residents’ personal property. The revised regulations state that a safe, homelike environment is a resident right and includes the right to receive treatment and care services safely.⁹⁹ As in the previous regulations, the facility must provide “[a] safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal property to the extent possible.” The facility must provide housekeeping and maintenance services, clean linens, private closet space, adequate and comfortable lighting, comfortable and safe temperatures, and comfortable sound levels. Under the revised regulations, the facility also must do the following:

- Ensure that the resident can safely receive treatment;
- Provide a safe physical layout that maximizes resident independence; and
- Exercise reasonable care for the protection of the resident’s property from loss or theft.¹⁰⁰

A facility cannot fulfill its duty to use reasonable care to protect the resident’s property in a manner that makes the property essentially inaccessible to the resident.

11. Grievances

The revised regulations have created procedural requirements for a facility to follow when handling grievances. As before, and consistent with the NHRA, a resident has the right to voice grievances without retaliation or the fear of discrimination or reprisal.¹⁰¹ In addition, a grievance can be made orally or in writing and can be submitted anonymously.

In a new requirement, the facility must

42183.

95 *Id.* at § 483.10(g)(2)(i).

96 *Id.* at § 483.10(g)(2)(ii).

97 *Id.* at § 483.10(h)(2).

98 81 Fed. Reg. at 68688, 68716.

99 42 C.F.R. § 483.10(i).

100 *Id.* at § 483.10(i)(1)(i)–(ii).

101 *Id.* at § 483.10(j).

establish a grievance policy to ensure prompt resolution of all grievances. The grievance policy must identify a grievance official who is responsible for overseeing the grievance process, including receiving, investigating, and tracking grievances through conclusion. The grievance official must lead any necessary investigation of the grievance while maintaining confidentiality of all information associated with the grievance, issue a written grievance decision to the resident, and coordinate with state and federal agencies as necessary. The written grievance decision must state the steps taken to investigate the grievance, pertinent findings and conclusions, whether the grievance was confirmed, and any corrective action taken or to be taken by the facility as a result of the grievance.¹⁰²

While the grievance is being investigated, the facility must “take immediate action to prevent further potential violations of any resident rights.”¹⁰³ The facility must immediately report “all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law.”¹⁰⁴ The facility must take appropriate corrective action in accordance with state law if a violation of resident rights is confirmed by the facility or an outside entity having jurisdiction.¹⁰⁵

Of course, grievance procedures are useful only if grievances are filed. The facility’s grievance policy must provide procedures for notifying residents of a) the right to file a grievance, b) the name of and

contact information for the grievance official, c) a reasonable expected time frame for completing a review of the grievance, and d) the right to obtain a written decision regarding the grievance.¹⁰⁶

12. Contact With External Entities

CMS specifies in the revised regulations, “A facility must not prohibit or in any way discourage a resident from communicating with federal, state, or local officials ... regarding any matter, whether or not subject to arbitration or any other type of judicial or regulatory action.”¹⁰⁷ Other provisions specify the resident’s right to receive notice of the contact information for state and local advocacy organizations, such as the state’s survey agency, long-term care ombudsman program, aging and disability resource center or other No Wrong Door program, and Medicaid fraud control unit. The facility must provide the notices orally or in writing in a format and language the resident understands.

D. Staffing and Training

Even though consumer advocates continued to seek minimum ratios of staff to residents, CMS instead continued to use more subjective standards based on “sufficient nursing staff.”¹⁰⁸ New language requires that all staff members have appropriate competencies and skill sets.¹⁰⁹ In determining the level of staffing that must be available, the facility must take into account the resident assessments, individual plans of care, and the number, acuity, and diagnoses of the resident population, as set forth in a formal assessment of the facility and its residents.¹¹⁰

102 *Id.* at § 483.10(j)(4)(v).

103 *Id.* at § 483.10(j)(4)(iii).

104 *Id.* at § 483.10(j)(4)(iv).

105 *Id.* at § 483.10(j)(4)(vi).

106 *Id.* at § 483.10(j)(4)(i).

107 *Id.* at § 483.10(k).

108 *Id.* at § 483.35.

109 *Id.*

110 Required at 42 C.F.R. § 483.70(e).

Requirements for licensed nurses and registered nurses are unchanged, as set by the NHRA.¹¹¹ Facilities are required to provide licensed nurses 24 hours per day and registered nurses 8 consecutive hours per day, 7 days per week. The revised regulations contain added language requiring a facility to ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents in accordance with the needs identified in the resident assessments and described in the care plans.¹¹² Providing care, as described in the regulations, includes “assessing, evaluating, planning and implementing resident care plans and responding to resident[s]’ needs.”¹¹³

Also unchanged is the requirement that the facility post nurse staffing information on a daily basis. This information includes the date, the total number and actual hours worked by nurses and certified nurse aides, and the resident census. The information must be posted in a prominent place readily accessible to residents and visitors.¹¹⁴

New in the regulations is the requirement that facilities develop, implement, and maintain an effective training program for all staff, contractors, and volunteers. The amount and type of training necessary must be based on the formal facility assessment.¹¹⁵ Training topics must include communication; residents’ rights and facility responsibilities; abuse, neglect, and exploitation; quality assurance and performance improvement; infection control; compliance and ethics; and behavioral health. This training program

must be put into effect by November 2019,¹¹⁶ with the exception of the training on abuse, neglect, and exploitation, which went into effect in November 2016.¹¹⁷ The abuse, neglect, and exploitation training must include information on the residents’ right to be free from abuse, neglect, and exploitation; it also must explain activities that constitute abuse, neglect, exploitation, and misappropriation of resident property and address reporting procedures and resident abuse prevention.¹¹⁸

Facilities also are required to provide at least 12 hours of in-service training annually for nurse aides.¹¹⁹ In-service training must include dementia management, resident abuse prevention, “areas of weakness as determined in nurse aides’ performance reviews and facility assessment,” and any special needs of residents as determined by facility staff.¹²⁰ Training on caring for individuals with cognitive impairments must be included for nurse aides who care for such individuals — and every nursing facility will have residents with cognitive impairments.¹²¹

E. Quality of Care

The revised regulations state, “Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident’s choices”¹²²

111 42 U.S.C. §§ 1395i-3(b)(4)(C), 1396r(b)(4)(C).

112 42 C.F.R. § 483.35(a)(3).

113 *Id.* at § 483.35(a)(4).

114 *Id.* at § 483.35(g).

115 *See id.* at § 483.70(e).

116 81 Fed. Reg. at 68,698.

117 *Id.*

118 42 C.F.R. § 483.95(c).

119 *Id.* at § 483.95(g)(1).

120 *Id.* at § 483.95(g)(2)–(3).

121 *Id.* at § 483.95(g)(4).

122 *Id.* at § 483.25.

This discussion on quality of care includes the following:

- **Vision and Hearing.** Residents must receive the assistive devices necessary to maintain vision and hearing ability as well as assistance in making appointments and arranging transportation to practitioners if necessary.¹²³
- **Skin Integrity.** Residents must be protected from developing pressure ulcers unless clinically unavoidable, and residents with pressure ulcers must receive treatment. Residents must also receive proper care and treatment to maintain good foot health as well as assistance in making appointments and arranging transportation to a qualified professional if necessary.¹²⁴
- **Mobility.** A resident's range of motion and mobility must be protected from decline unless a clinical condition makes decline unavoidable.¹²⁵
- **Accidents.** Facilities must ensure that the environment is as free as possible from accident hazards and that each resident receives adequate supervision and assistive devices to prevent accidents.¹²⁶
- **Incontinence.** Facilities must ensure that continent residents maintain their continence unless a clinical condition makes this impossible. Residents must not be catheterized unless clinically necessary, and residents who are catheterized must be assessed for catheter removal as soon as possible. Incontinent residents must be assessed for treatment and services to prevent infection and to restore continence to the extent possible.¹²⁷
- **Assisted Nutrition and Hydration.** Facilities must ensure that residents maintain their weight unless a clinical condition or their preferences make this impossible. Residents must be offered sufficient fluids to maintain proper hydration. Residents' ability to eat orally must be maintained unless clinically contraindicated. Residents must consent to enteral feeding and must receive appropriate treatment and services to restore oral eating, if possible, and to prevent complications.¹²⁸
- **Pain Management.** Pain management must be provided to residents who require it. Pain management must be consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.¹²⁹
- **Dialysis.** Dialysis services must be provided to residents who require them. Dialysis services must be consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.¹³⁰
- **Trauma-Informed Care.** Residents who are trauma survivors must receive culturally competent trauma-informed care. Residents' experiences and preferences must be taken into account in order to eliminate or mitigate triggers that may cause retraumatization.¹³¹
- **Bed Rails.** Facilities must attempt to use alternatives prior to installing a side or bed rail. If a side or bed rail is used, the facility must ensure proper installation and maintenance. Prior to installation, the facility must assess a resident's risk of entrapment, review the risks and benefits of the rails with the resident

123 *Id.* at § 483.25(a).

124 *Id.* at § 483.25(b).

125 *Id.* at § 483.25(c).

126 *Id.* at § 483.25(d).

127 *Id.* at § 483.25(e).

128 *Id.* at § 483.25(g).

129 *Id.* at § 483.25(l).

130 *Id.*

131 *Id.* at § 483.25(m).

or representative, and obtain informed consent.¹³²

F. Pharmacy Services and Medications

Pharmacy services, including the dispensing of routine and emergency drugs, must be provided to meet the needs of each resident.¹³³ If unlicensed personnel (e.g., medication assistants) are permitted under state law to administer drugs, the facility may allow it, but only under the general supervision of a licensed nurse.¹³⁴ A licensed pharmacist must be consulted in the provision of pharmacy services, and he or she must establish a system for recording and accounting for controlled substances.¹³⁵

Carried over to these revised regulations is the requirement that a licensed pharmacist conduct a drug regimen review for each resident at least monthly.¹³⁶ New language requires the drug regimen review to include a review of the resident's medical chart,¹³⁷ and the regulations expand the reporting of irregularities to include unnecessary drugs.¹³⁸ Additional documentation of any irregularities is required, including the fact that an irregularity has been reviewed by the attending physician and what action, if any, has been taken to address it. The attending physician must provide a rationale if he or she does not change the medication that is the cause of the irregularity.¹³⁹

Also new to the regulations is a requirement that the facility develop and maintain policies and procedures for the

monthly drug regimen review that includes time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.¹⁴⁰

Each resident's drug regimen must be free from drugs that are "unnecessary," which is defined as drugs used in excessive doses, for excessive durations, without adequate monitoring, or without adequate indications for use. Also included are drugs used in the presence of adverse consequences, which indicates the dose should be reduced or discontinued.¹⁴¹

The revised regulations contain important new language related to the use of psychotropic drugs, requiring facilities to ensure that residents who have not used psychotropic drugs are not given them unless necessary to treat a specific condition diagnosed and documented in the clinical record.¹⁴² Residents who have been prescribed psychotropic drugs must receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue use of the drugs.¹⁴³

The regulations also now require facilities to ensure that residents do not receive psychotropic drugs as a PRN (as needed) order unless medically necessary to treat a specific diagnosed condition that is documented in the clinical record.¹⁴⁴ Additionally, PRN orders for psychotropic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner believes it is appropriate to extend the order and documents that reasoning. For antipsychotic

132 *Id.* at § 483.25(n).

133 *Id.* at § 483.45(a).

134 *Id.* at § 483.45.

135 *Id.* at § 483.45(b).

136 *Id.* at § 483.45(c)(1).

137 *Id.* at § 483.45(c)(2).

138 *Id.* at § 483.45(c)(4).

139 *Id.*

140 *Id.* at § 483.45(c)(5).

141 *Id.* at § 483.45(d).

142 *Id.* at § 483.45(e).

143 *Id.* at § 483.45(e)(1).

144 *Id.* at § 483.45(e)(3).

medications, the limit on PRN orders also is 14 days, with the physician required to evaluate the resident prior to ordering any extension.¹⁴⁵

G. Transfer and Discharge Procedures

1. Transfer and Discharge

Under the NHRA, a nursing facility can transfer a resident against his or her will for one of six reasons only:

1. The resident needs a level of care that the nursing facility cannot provide;
2. The resident does not need nursing facility care;
3. The resident's presence endangers the health of others at the facility;
4. The resident's presence endangers the safety of others at the facility;
5. The resident owes money for nursing facility care despite having received adequate notice; or
6. The nursing facility is going out of business.¹⁴⁶

The regulations expand slightly on these six reasons. Following the statutory language, the regulations continue to specify, "For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid."¹⁴⁷ At a minimum, this language specifies that a facility cannot impose a private-pay rate on a resident who becomes Medicaid eligible. A Kansas appellate court has interpreted this language more broadly, holding that once a resident becomes Medicaid eligible, the resident cannot be transferred or discharged for failure to pay a debt incurred during private-pay status.¹⁴⁸

The regulations now bar transfer/discharge for nonpayment when the resident has submitted a claim for payment to a third party.¹⁴⁹ This protection is most relevant when a resident has filed a Medicaid application. While the Medicaid program is considering the application — and, potentially, while a hearing officer is considering an appeal to an initial denial — the facility cannot proceed with a transfer/discharge based on nonpayment.

Regarding transfer/discharge based on purported danger to others, the regulations now specify that the endangerment must be "due to the clinical or behavioral status of the resident."¹⁵⁰ It is far from clear whether this additional language will be a significant check on facilities, given the potentially broad reach of the term "clinical or behavioral status."

The regulations now include the important protection that a facility may not transfer or discharge a resident while an appeal is pending.¹⁵¹ This new provision protects residents both from improper transfer/discharge and from being threatened with transfer/discharge during an appeal's pendency. The regulations provide an exception to this protection if, by staying in the facility through the appeal decision, the resident would endanger his or her health or safety or the health or safety of others in the facility.

Consistent with the statutory authority,

L.L.C. v. Ermey, 203 P.3d 4, 8–9 (Kan. App. 2009); *but see Dayspring of Miami Valley v. Shepherd*, 2007 Ohio 2589 (Ohio App. 2d Dist. 2007) (hearing officer had erred by treating payment of current bill as reason to deny discharge for nonpayment).

149 42 C.F.R. § 483.15(c)(1)(i)(E). This same protection previously was located in the CMS surveyor's guidelines but not in the regulations.

150 *Id.* at § 483.15(c)(1)(i)(C).

151 *Id.* at § 483.15(c)(1)(ii).

145 *Id.* at § 483.45(e)(3)–(5).

146 42 U.S.C. §§ 1395i-3(c)(2)(A), 1396r(c)(2)(A).

147 42 C.F.R. § 483.15(c)(1)(i)(E); *see* 42 U.S.C. § 1396r(c)(2)(A).

148 *Pioneer Ridge Nursing Facility Operations*,

the regulations continue the requirement of physician documentation of certain allegations. If a resident allegedly endangers the health or safety of others, a physician must document the alleged endangerment in the resident's file. If transfer/discharge is based on allegations that the resident needs either a higher or lesser level of care, the required documentation must be performed by *the resident's physician* because in these cases transfer/discharge supposedly is for the resident's benefit.¹⁵²

In a new protection, the regulations now require additional documentation when a facility alleges that it no longer can meet a resident's needs. In these situations, the resident's physician must list "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)."¹⁵³ Ideally, this requirement will serve as a check on a cynical facility's inclination to rid itself of residents who require relatively more care. Too many facilities state broadly that a resident's care needs are too great, but these same facilities likely are less quick to take action if forced to specify their supposed inability to provide required care and the ability of another nursing facility to provide the care.

Another check on the "we can't meet your needs" transfer/discharge is a new requirement that a facility during admission provide "notice of special characteristics or service limitations of the facility."¹⁵⁴ If a facility subsequently claims that it cannot meet a resident's needs, the resident may be able to point to the fact that the facility never disclosed any relevant service limita-

tions and thus should not be able to rely on a supposed inability to provide necessary services.

The regulations continue to require written notice of transfer/discharge, consistent with statutory requirements.¹⁵⁵ Notice must be provided to the resident and the resident's representative.¹⁵⁶ Generally, this notice must be provided at least 30 days prior to the proposed transfer/discharge, although the exceptions are many. Specifically, notice may be provided "as soon as practicable before transfer or discharge" when the resident's presence endangers the health or safety of others, the resident's needs necessitate an immediate transfer, an improvement in the resident's health enables a more immediate transfer/discharge, or the resident has resided in the facility for less than 30 days.¹⁵⁷

A new provision requires that notice also be sent to the state's long-term care ombudsman program.¹⁵⁸ To implement this requirement, most ombudsman programs are issuing instructions on how they want to receive notices and whether notices should be sent to state or local offices.

The notice-to-ombudsman requirement has placed additional attention on a continuing issue — When is a transfer/discharge considered involuntary for the purpose of requiring notice? Perhaps surprisingly, the federal transfer/discharge law applies on its face to all transfers and discharges, regardless of whether the resident is leaving against his or her will. The statutory language states that a facility "must permit each resident to remain in the facility and must not transfer or discharge the resident from the facility un-

152 *Id.* at § 483.15(c)(2)(ii); see 42 U.S.C. §§ 1395i-3(c)(2)(A), 1396r(c)(2)(A).

153 42 C.F.R. § 483.15(c)(2)(i)(B).

154 *Id.* at § 483.15(a)(6); see *supra* at II.A.4 for previous discussion of this issue.

155 42 U.S.C. §§ 1395i-3(2)(B), 1396r(2)(B).

156 42 C.F.R. § 483.15(c)(3).

157 *Id.* at § 483.15(c)(4).

158 *Id.* at § 483.15(c)(3)(i).

less” one of the six reasons for transfer/discharge can be proved.¹⁵⁹ The regulatory language is virtually identical.¹⁶⁰

As a practical matter, however, it makes little sense for a facility to issue a transfer/discharge notice if a resident chooses to leave a nursing facility and, for example, return home. CMS has addressed this issue through subregulatory guidance that imposes notice requirements on a transfer or discharge when initiated by a facility but not when initiated by a resident. A transfer/discharge is considered resident initiated when the resident or representative “has given written or verbal notice of [his or her] intent to leave the facility.”¹⁶¹ Resident initiation is not indicated by a resident saying generally that he or she wants to go home.¹⁶² Furthermore, a transfer/discharge is considered facility initiated if it “did not originate through [the] resident’s verbal or written request, and/or is not in alignment with the resident’s stated goals for care and preferences.”¹⁶³

One contested and important matter is the issuance of notice when a resident is concluding his or her Medicare-funded stay in a nursing facility. Many reimbursement-focused facilities see this time as an opportunity to move a Medicaid-eligible resident out of the nursing facility in order to bring in additional Medicare-reimbursed residents. In some instances, facilities claim that they are rehabilitation specialists and do not provide custodial care or long-term care. Such claims, however, fly in the face of the NHRA’s requirements that a resi-

dent be allowed to remain in the facility unless the facility can prove one of the six reasons for transfer/discharge. The federal law prioritizes a resident’s stability and dignity over the facility’s preference to receive higher reimbursement or specialize in a particular type of care.

The surveyor’s guidelines address the issue of transfer/discharge following a Medicare-funded stay, but the guidelines are only marginally helpful:

Discharges following completion of skilled rehabilitation may not always be a resident-initiated discharge. In cases where the resident may not object to the discharge, or has not appealed it, the discharge could still be involuntary and must meet all requirements of this regulation.¹⁶⁴

Advocates for residents should cite this language to push back against facilities’ narrative that a Medicare-reimbursed resident always wants to leave when the Medicare reimbursement concludes. That narrative is true in some cases but is completely false in many others. Numerous Medicare-reimbursed residents are interested in nursing facility care after the conclusion of a Medicare-funded stay, and they are at risk of their nursing facility giving them the impression that they must leave, or should leave, when the Medicare-funded stay ends. To protect residents in these situations, facilities should provide the notice required by law. The notice is a vital check on the inclinations of some facilities to discard residents at the conclusion of their Medicare-funded stay.

159 42 U.S.C. §§ 1395i-3(c)(2)(A), 1396r(c)(2)(A).

160 42 C.F.R. § 483.15(c)(1)(i).

161 Ctrs. for Medicare & Medicaid Servs., surveyor’s guideline on 42 C.F.R. § 483.15(c), *supra* n. 87.

162 *Id.*

163 *Id.*

2. Returning to Nursing Facility After Hospitalization

The relevant statutory authority addresses two related concepts: bed holds

164 *Id.*

and the right to return. The ability to “hold” a bed is set by state law, and the federal law requires that the nursing facility notify the resident of his or her rights under state law. This notification must be given twice: before and when the resident is transferred to a hospital.¹⁶⁵ Most nursing facilities provide the before-transfer notice when the person is first admitted to the nursing facility. Holding a bed requires that the nursing facility be paid for the relevant days, either by the resident or by a third-party payer (often Medicaid).

In thinking about bed hold rights, advocates should not ignore the argument that a resident holds a bed whenever he or she pays in advance. If a resident pays out of pocket, for example, for an entire month in advance, the resident should be considered to be under a bed hold through that entire month even if the bed hold established by the state’s nursing facility law has expired.

The right to return to the nursing facility does not depend on a bed being held. Under the NHRA, a resident has a right to return from the hospital to the next available semiprivate room in the facility.¹⁶⁶ This right to return applies when the bed hold has been exceeded, the state provides no bed hold rights, and/or the resident chose not to pay for a bed hold.

Although the statutory right to return applies only to Medicaid-eligible residents, the revised regulations extend the right to residents whose nursing facility care will be reimbursed by Medicaid or Medicare. Also, the revised federal regulations establish the resident’s right to return to his or her original room in the nursing facility if that room is available.¹⁶⁷

Another welcome regulatory change is a provision that addresses situations in which a facility refuses to honor a resident’s bed hold or right to return. Some nursing facilities consider hospitalization as an opportunity to rid themselves of a resident who is considered undesirable or less profitable for one reason or another. Refusing to accept a resident who is returning from the hospital puts the resident in an extremely difficult situation because the hospital will not want to retain him or her beyond the (probably limited) time allocated by Medicare or another insurer.

Under the revised regulations, if a facility “determines that a resident who was transferred with an expectation of returning to the facility cannot return to the facility,” the facility must comply with transfer/discharge requirements.¹⁶⁸ Furthermore, the surveyor’s guidelines make it clear that “the resident must be permitted to return and resume residence in the facility while an appeal is pending.”¹⁶⁹

H. Protections Against Abuse, Neglect, and Exploitation

Under the NHRA, a nursing facility resident has “the right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident’s medical symptoms.”¹⁷⁰ The regulations restate these rights with somewhat more detail, specifying that, regarding restraints, the facility “must use the least restrictive alternative for the least amount of time

168 *Id.* at § 483.15(e)(1)(ii).

169 Ctrs. for Medicare & Medicaid Servs., surveyor’s guideline on 42 C.F.R. § 483.15(e)(1), *supra* n. 87.

170 42 U.S.C. §§ 1395i-3(c)(1)(A)(ii), 1396r(c)(1)(A)(ii).

165 42 U.S.C. § 1396r(c)(2)(D)(i), (ii); 42 C.F.R. § 483.15(d).

166 42 U.S.C. § 1396r(c)(2)(D)(iii).

167 42 C.F.R. § 483.15(e)(i).

and document ongoing re-evaluation of the need for restraints.”¹⁷¹

In addition, a resident or representative should not overlook the resident’s ultimate control over the use of restraints — the right under state informed consent law to either consent to or refuse restraint use. A resident or representative does not have to prove that a physical restraint is being used for discipline or convenience and can refuse restraints without giving a reason.

Under the regulations, one facet of abuse prevention is hiring trustworthy persons. A facility must not employ anyone who has the following characteristics:

- Found by a court to be guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment;
- Had a finding entered in the state nurse aide registry based on one of these five transgressions; or
- Has a disciplinary action against his or her professional license due to one of the same five transgressions.¹⁷²

Likewise, the facility must take steps to prevent and report abuse. A facility’s policies must prohibit abuse and provide training for employees on recognizing and reporting abuse and investigating abuse allegations.¹⁷³ All alleged abuse violations must be reported to the facility administrator and to “other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.”¹⁷⁴ More generally, if the facility has information that an employee is unfit for assisting residents, the

facility must make a report to the relevant licensing agency or the state nurse aide registry.¹⁷⁵

In addition, the Affordable Care Act has added a requirement for reporting suspected crimes to law enforcement.¹⁷⁶ As this requirement is implemented in federal regulations, a facility must notify managers, employees, and contractors of their duty to report to law enforcement “any reasonable suspicion of a crime” against a resident.¹⁷⁷ The report must be made within 2 hours if serious bodily injury has occurred; otherwise, the report must be made within 24 hours. The report must be made to the state licensing and certification agency along with at least one local law enforcement agency. To ensure that reports are not suppressed, a facility is prohibited from retaliating against a reporter.¹⁷⁸

III. Advocacy and Enforcement Issues

The nursing facility lobby has demonized the revised regulations to a certain extent, referring to them as the “Mega Rule” collectively and as “sweeping changes” that are “onerous and unnecessary.”¹⁷⁹ These criticisms are overblown. For example, CMS noted that commenters who believe the proposed rules are overly burdensome often mischaracterize existing requirements as new rules, indicating a lack of knowledge of the current rules for nursing

171 42 C.F.R. § 483.12(a)(2).

172 *Id.* at § 483.12(a)(3).

173 *Id.* at §§ 483.12(b), 483.95(c).

174 *Id.* at § 483.12(c)(1).

175 *Id.* at § 483.12(a)(4).

176 *See* 42 U.S.C. § 1320b-25.

177 42 C.F.R. § 483.12(b)(5)(i)(A).

178 *Id.* at § 483.12(b)(5)(iii).

179 Am. Health Care Ass’n & Natl. Ctr. for Assisted Living, *Requirements of Participation for Nursing Centers Are Onerous and Unnecessary Regulation*, https://www.ahcancal.org/advocacy/issue_briefs/Issue%20Briefs/RoP%20Updated%20Ask%20v2.pdf (accessed Jan. 5, 2018).

facilities.¹⁸⁰ In contrast, consumer advocates argue that the proposed rules do not go far enough in making needed changes and merely reflect current practices, which may be inadequate. Consumer advocates' top priority for the revised regulations was a minimum staffing standard, which is widely considered the single most important factor in improving quality of care. Improved staffing standards would have included minimum staff-to-resident ratios, minimum hours of care, and a registered nurse on duty 24 hours a day.

A. Proposed New Rule on Arbitration Agreements

As discussed previously,¹⁸¹ the revised regulations prohibit a nursing facility from obtaining any arbitration agreement at the time of admission. Unfortunately for consumers, this arbitration ban has been enjoined by a lawsuit brought by a nursing facility trade association, and CMS has declined to pursue an appeal.¹⁸²

In the meantime, CMS has solicited comments on a revision of the regulations that would not only reverse the prohibition but also establish a framework for nursing facilities to require arbitration agreements as a condition of admission.¹⁸³ Such a regulation, if promulgated, would be a significant backwards step. Currently, if a nursing facility requires arbitration as a condition of admission, the facility's requirement is seen as a strong indication that the arbitration agreement is unconscionable and thus unenforceable.¹⁸⁴ That

indicator of unconscionability would be greatly weakened if federal regulations were to set standards based on arbitration being a requirement for admission.

B. Re-evaluation of Sections of the Final Rule and Implementation Delays

Since the publication and effective date of the final rule, implementation of the regulations as written has not been without challenges. The new administration and Congress elected in November 2016 have pursued an agenda of deregulation,¹⁸⁵ and the nursing facility industry has actively sought to revise or repeal sections of the regulations they claim to be burdensome and to delay implementation of Phase 2 and 3 requirements.¹⁸⁶ Six months

185 Ltr. from 120 H. of Reprs. members to Dept. of Health & Human Servs. Acting Sec. Eric Hargan & Ctrs. for Medicare & Medicaid Servs. Adminstr. Seema Verma, *Concerns About CMS Rule Updating "Requirements of Participation" for Skilled Nursing Facilities/ Nursing Facilities (SNF/NF)*, <http://renacci.house.gov/cache/files/8ad42967-7fd9-4d12-aba-f65dda6e0426/renacci-rop-final-letter-10.11.17.pdf> (Oct. 11, 2017).

186 Holly Fechner & Matthew S. Shapanka, *Use of the Congressional Review Act in the 115th Congress to Overturn Obama Administration Regulations*, Natl. L. Rev., <https://www.natlawreview.com/article/use-congressional-review-act-115th-congress-to-overturn-obama-administration> (Nov. 29, 2016); Ltr. from Mark Parkinson, Pres. & CEO, Am. Health Care Ass'n & Natl. Ctr. for Assisted Living, to Dept. of Health & Human Servs. Sec. Thomas E. Price, *Concerns About Medicaid Underfunding, Medicare Cuts, and Over-Regulation*, <http://www.ihca.com/Files/Comm-Pub/AHCA-Final-Price-Ltr-3.9.17.pdf> (Mar. 9, 2017); comments by Jennifer Hilliard, *LeadingAge Calls for Delay, Revision of Nursing Home Requirements of Participation*, LeadingAge, <http://www.leadingage.org/regulation/leadingage-calls-delay-revision-nursing-home-requirements-participation> (Aug. 28, 2017).

180 81 Fed. Reg. at 68692–68695.

181 See *supra* at II.A.3.

182 See *Am. Health Care Ass'n v. Burwell*, 217 F. Supp. 3d 921 (N.D. Miss. 2016).

183 82 Fed. Reg. at 26649 (June 8, 2017).

184 See *e.g. Ostroff v. Alterra Healthcare Corp.*, 433 F. Supp. 2d 538, 544 (E.D. Pa. 2006) (arbitration as condition of admission).

after issuance of the revised regulations, CMS identified several areas of the regulations it intends to review “for modification or removal in an effort to reduce the burden and financial impact imposed on LTC [long-term care] facilities.”¹⁸⁷ Those areas are the grievance process, quality assurance and performance improvement, and discharge notices to the long-term care ombudsman program. Feedback is being sought on “any additional areas of burden reduction and cost savings in LTC facilities.”¹⁸⁸

In addition, CMS indicated its intent to institute a moratorium on enforcement remedies for specific Phase 2 requirements. Civil money penalties, denial of payment, and/or termination as an approved Medicare/Medicaid nursing facility are not being used for an 18-month period beginning November 2017. Facilities found out of compliance with Phase 2 requirements may instead be given a directed plan of correction or directed in-service training.¹⁸⁹ Also, CMS is “holding constant for one year” the inspection ratings on Nursing Home Compare for any surveys taking place after November 28, 2017.¹⁹⁰

Lastly, in Fall 2017, CMS indicated its intent to issue a new proposed rule in 2018 that would reform the long-term care facility requirements that “CMS has identified as unnecessary, obsolete or excessively burdensome on facilities.”¹⁹¹

C. Survey Process

Although the 2016 issuance of the revised federal regulations has made significant changes to the substantive standards governing nursing facilities, that regulatory package has made few changes to the enforcement system. The main changes are modified definitions of “abuse,” “neglect,” “nurse aide,” “substandard quality of care,” and other terms.¹⁹²

Before the release of the revised regulations, however, CMS revised the guidance on assessment of money penalties. The central issue is whether money penalties should be assessed on a per instance or per day basis. Per day penalties generally are considered a more impactful remedy because the amount of the penalty continues to mount until the facility remedies the problem.

Under the new guidance, survey agencies generally will assess per instance penalties for violations that begin prior to a survey and are deemed resolved at the time of the survey. Among such violations, however, a per day penalty will be assessed for those of a relatively higher scope and severity, for certain violations involving abuse, and for repeat violations of a higher scope and severity.¹⁹³

187 82 Fed. Reg. at 21088–21089 (May 4, 2017).

188 *Id.* at 21089.

189 CMS S&C Memo 18-04-NH (Nov. 24, 2017), <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-18-04.pdf>.

190 Memo. from David R. Wright, Dir., Ctrs. for Medicare & Medicaid Servs., Ctr. for Clinical Stands. & Quality, Survey & Certification Group, to St. Survey Agency Dirs., *Revision to State Operations Manual (SOM) Appendix PP for Phase 2, F-Tag Revisions, and Related Issues*, S&C: 17-36-NH, <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Survey-and-Cert-Memo-Revision-SOM-Appendix-PP-Phase-2.pdf> (June 30, 2017).

191 Unified Agenda of Regulatory and Deregulatory Actions, Fall 2017, RIN: 0938-AT36, https://www.reginfo.gov/public/do/eAgendaViewRule?pubId=201710&RIN=0938-AT36&operation=OPERATION_PRINT_RULE.

192 See 42 C.F.R. § 488.301.

193 Ctrs. for Medicare & Medicaid Servs., *CMP Analytic Tool, User's Guide*, Version 1.3,

If, on the other hand, a violation exists at the time of the survey, CMS guidance directs default to a per day penalty. The exceptions to this default, however, are significant. Per instance penalties are appropriate for addressing a “singular event of actual harm” of a specified scope and severity and for ongoing noncompliance with a certain scope and severity of violation if the facility has a “good compliance history.”¹⁹⁴

IV. Conclusion

The revised regulations contain both positives and negatives for nursing facility residents and their advocates. The positives include expanded requirements for person-centered care, care planning, and resident choice and participation in health care services. The revised regulations also strengthen the NHRA’s prohibitions against facilities requiring a third-party guarantee of payment or a waiver of legal rights, and protections for residents from improper transfer/discharge. In addition, the regulations have added requirements for a facility grievance official and procedures.

It is disappointing, however, that the revised regulations do not require a registered nurse around the clock or a minimum staffing standard. Even though un-

necessary restraints are included in the definition of “abuse” and the requirements for drug regimen reviews and reporting of unnecessary drugs were expanded, the revised regulations compromise the focus on ending the misuse of antipsychotic medications.

In addition, the Trump administration has proposed a repeal of the ban on predispute arbitration agreements and delayed enforcement remedies for certain Phase 2 requirements. The administration is also considering the repeal or further modification of other revised regulations (e.g., regulations on grievance procedures, quality assurance, and ombudsman discharge notices).

Even though CMS and the states are responsible for implementing these regulations, regulation implementation, if left solely to government agencies and providers, is usually scattershot and inadequate. For the revised regulations to truly become the national standard of care, nursing facility residents and their advocates must be prepared to assert resident rights over and over again. Another unfortunate reality is that nursing facilities may be hostile or apathetic toward the revised regulations and the survey agencies can only do so much, given that federal law requires surveys only once a year. For these reasons, it is up to residents, families, and advocates to be knowledgeable about the federal law and make nursing facilities accountable when they fall short.

§ 2.4.2.2, <http://ltombudsman.org/uploads/files/library/cmp-analytic-tool-user-guide.pdf> (accessed Jan. 5, 2018).

194 *Id.* at § 2.4.2.3.

