Legal Tools for Ombudsmen

How to Obtain Quality Care Using the Law and Regulations

Kathy Swanson and Robyn O'Neill
Legal Assistance Foundation
of Metropolitan Chicago

Legal Authority

- Older Americans Act
- Omnibus Budget Reconciliation Act of 1987
- Medicaid Regulations
- Code of Federal Regulations
- State Operations Manual

Older Americans Act

- **Title 42 Chapter 35, Subchapter XI, subpart ii of the United States Code**

- Establishes the Office of the Long-Term Care Ombudsman within the Administration on Aging.

- **Section 3058g(3)** lists the functions of the State Ombudsman program which include:

  (A) identify, investigate and resolve complaints…;

  (B) provide services to assist in protecting the health, safety, welfare and rights of residents;

  (C) inform residents about means of obtaining services…;

  (D) ensure that residents have regular and timely access to the services provided through the Ombudsman and that residents and complainants receive timely responses…;

Older Americans Act

(E) represent the interests of residents before governmental agencies and seek administrative, legal and other remedies to protect the health, safety, welfare and rights of residents;

(F) provide administrative and technical assistance to designated entities participating in the program;

(G)(i) analyze, comment on and monitor the development and implementation of federal, state and local laws, regulations…;

(ii) recommend changes …;

(iii) facilitate public comment…;

Older Americans Act

(H)(i) provide training for representatives of the State Ombudsman Office;

(ii) promote the development of citizen organizations…;

(iii) provide technical support for the development of resident and family councils…; and

(I) carry out such other duties as the Assistant Secretary determines to be appropriate.

Older Americans Act

- **Section 3058g(5)(A)** gives authority to the State Ombudsmen to designate local entities.
- **Section 3058c(5)(B)** lists the duties of the local programs which include:

  (i) provide services to protect the health, safety, welfare and rights of residents;

  (ii) ensure residents have regular and timely access to the representatives;

  (iii) identify, investigate, and resolve complaints made by or on behalf of residents;

  (iv) represent the interests of residents before governmental agencies and seek relief;

  (v)(1) review and comment on legislation and **(2)** facilitate the public to comment on laws;

  (vi) support the development of resident and family councils; and

  (vii) carry out other activities that the State Ombudsman determines to be appropriate.

Older Americans Act

- **Section 3058g(5)(D)** requires the State Ombudsmen to establish policies and procedures for monitoring local programs to carry out the duties of the office including maintaining confidentiality of Ombudsman files and prevention of conflict of interests.

- **Section 3058g(5)(D)(b)** requires the State Ombudsmen ensure that local Ombudsmen have access to facilities and residents.

- **Section 3058g(5)(D)(c)** requires the State Ombudsmen to establish a uniform system to collect and analyze data.

Omnibus Budget Reconciliation Act ‘87

- The Omnibus Budget Reconciliation Act of 1987 (OBRA ’87) is the federal Nursing Home Reform Act which created a set of national minimum standards of care and rights for people living in certified long-term care facilities.
- Signed into law by President Reagan in 1987 after the Institute of Medicine conducted a study of how to better regulate quality of care in certified facilities
- The first major overhaul of certified long-term care facilities since the enactment of Medicare and Medicaid in 1965
- Applies to facilities that have Medicaid or Medicare beds only
- Recognized the role performed by the Ombudsman for residents
- Described the advocacy roles of the Ombudsman and regulations and other tools given to Ombudsmen to serve residents’ interests

Omnibus Budget Reconciliation Act ‘87

- Requires facilities to help residents to attain and maintain the residents’ highest practicable physical, mental and psycho-social well being, including:
    - emphasis on quality of life as well as quality of care;
    - an expectation that residents’ ability to perform activities of daily living (ADLs), including the ability to walk, will be maintained or improved unless a medical condition prevents maintenance or improvement;
    - creation of individualized care plans;
    - a required minimum of 75 hours of training for nurses’ aides;
    - a right to return to the facility after a hospital stay if the facility can still meet a resident’s needs;

Omnibus Budget Reconciliation Act ‘87

- right to have and participate in resident and family councils;
- right to be free of physical and chemical restraints;
- Prohibits facilities from requiring family members to pay for care out of their assets; and
- the imposition of remedies for non-compliance.

- Surveyors no longer spend all of their time with staff or with facility records but rather talk with residents and families and observe dining and medication administration as well. Surveyors must have conversations with residents/families about life in the nursing home.
- Long-Term Care Ombudsmen roles are clearly defined.

Medicaid Regulations

Medicaid is a federal/state needs based program which helps pay for medical care and services.

- **42 CFR 431** establishes minimum requirements that states must meet, but also allow states some leeway. There must be a single state agency designated to administer Medicaid – this does not preclude states from having regional or local offices.

- **42 CFR 431.18** requires states to facilitate access by the public to Medicaid rules and policies.

- **42 CFR 431.20** ensures that all facilities that are certified to participate in the Medicare and/or Medicaid programs meet the requirements of 42 CFR 483.

- **42 CFR 431.151** requires states to establish an appeal process for facilities that wish to challenge a department decision including the right to a fair hearing.

Medicaid Regulations

- **42 CFR 431.200** requires states to establish a fair hearing process for individuals who are denied or when an application is not acted upon promptly.
- **42 CFR 431.205** requires states to notify applicants of the right to a hearing and the right to legal counsel or representation at the hearing by anyone of the applicant's choosing including an Ombudsman.
- **42 CFR 431.10** requires the notice to include:
  - a statement of the action taken;
  - the reason for the action;
  - the specific regulation that supports the action taken; and
  - an explanation of the applicant's rights.
- **42 CFR 431.701** is the list of definitions.

Code of Federal Regulations

- Codification of regulations published by the executive departments and agencies of the Federal Government of the United States
- Divided into 50 titles that represent broad areas subject to federal regulation
- Title 42 regulates public health matters.
- Chapter IV contains the Centers for Medicare and Medicaid Services, Department of Health and Human Services regulations.
- The federal regulations are treated by the courts as legally binding, provided the regulations are reasonable interpretations of the underlying statutes.

42 CFR 483

- **42 CFR 483** contains the requirements for long-term care facilities and is a comprehensive tool created for the protection of residents
- Applies to facilities that participate in the Medicare and/or Medicaid programs
- Facilities that are solely private pay adhere only to the state statutes and the state public health regulations, not the federal law.
- Has detailed explanations of residents rights, admission and discharge rights, quality of life, resident assessment, nursing-dietary-physician-dental and pharmacy services, physical environment requirements, levels of care, nurse aid registry, etc.

42 CFR 488

- **42 CFR 488** contains the survey, certification, and enforcement procedures to be followed by the state survey entity.
- Requires the state survey agency to perform unannounced surveys every 12 to 15 months
- Emphasizes resident outcomes based on observations of residents, not only examination of charts (This section is long but well worth reading if you are going to observe a survey in progress.)
- Describes enforcement of compliance for long-term care facilities with deficiencies.

State Operations Manual

- Created by the Centers for Medicare and Medicaid Services (CMS)
- Regulatory guidance for Skilled Nursing Facilities
- Interesting fact: Surveys show 38% of LTC staff find the SOM difficult to use.
- The SOM contains citations to federal regulations, investigative procedures, probes, and interpretive guidelines for public health surveyors.
- 8 Chapters along with Appendices and Exhibits.

State Operations Manual

- **Chapter 1**

  Program Background and Responsibility

- **Chapter 2**

  Certification Surveys – Citations and Responsibilities

  (Identification of Providers and Suppliers and Related Pre-survey Activities)

- **Chapter 3**

  Adverse Actions

  Section 3000 B requires survey agencies to coordinate with the State Ombudsman programs and to notify with the State Ombudsmen of decisions to initiate proceedings.

- **Chapter 4**

  Program Administration and Fiscal Management

State Operations Manual

- **Chapter 5**
  Complaint Process
  Sections 5300 through 5390 include specific instructions to surveyors for nursing home complaints

- **Chapter 6**
  Program Background and Actions Related to Certification

- ***Chapter 7***
  Survey Enforcement Process for Skilled Nursing Facilities and Nursing Facilities

- **Chapter 8**
  Standards for States

State Operations Manual

- **Appendix P**
  Survey Protocol for Long-Term Care
- **Appendix PP**
  Interpretive Guidelines for Long-Term Care
- **Appendix Q**
  Determining Immediate Jeopardy
- **Appendix R**
  Resident Assessment for Long-Term Care

Case Analysis

Intake

- Date Complaint Received
- Complainant's Name
- Complainant's Relationship to the Resident
- Resident's Name
- Description of the complaint with as much detail as possible including names, dates, witnesses, other residents involved, etc.

Case Analysis

The Resident

- The information below should be included in the documentation:
  - Date of first contact
  - If the resident alert and oriented to time, place and person
  - If the resident able to answer questions appropriately
  - If the resident capable of giving information to assist in the investigation
  - If the resident capable of understanding the compliant investigation and resolution process
  - If the resident agrees with the complaint as reported by the complainant
  - If the resident consents to allow the Ombudsman to investigate the complaint

Case Analysis

- ***Tip**: If you are unsure of the resident's ability to understand the complaint, make a second visit. If the resident is able to recall the discussion even if they have forgotten some details, you can proceed.*

- If the resident does not recall the meeting, you will need consent from the resident's designated decision maker, if one exists.

Case Analysis

The Complaint(s)

- Describe the complaint(s)
- Which complaint is most important to the resident?
- What resolution does the resident or representative want?
- Are the resident's expectations realistic?
- Can any of the complaints be treated as a "systemic" complaint?
- ***Tip:*** *If the resident/complainant has unrealistic expectations, explain what a realistic outcome is. Do not make promises you can't keep.*

Case Analysis

Verification of a Complaint and Development of a Plan

- Figure out what additional information you need.
- Think about who else you need to interview.
- Check if the facility is certified for Medicare or Medicaid.
- Determine which laws, regulation and policies do you need to research.
- Determine if you need to review the resident's records.
- If yes, do you have a signed consent?
- Determine if the complaint is valid.

Case Analysis

- Does the resident agree with your proposed plan of action and give express consent to proceed?
- If yes, proceed.
- If no, you must stop work - an Ombudsman cannot proceed without the resident’s permission.
- Document all of the above in your case notes.

Case Analysis

Resolution

- Did the plan work?
- Is the resident happy with the results?
- If the complaint is not resolved, why not?
- Is there any other way to resolve the complaint?

Q and A

Our Case Examples

Hair Cut Case

The Facts:

- Mr. J's wife informs us that the facility is charging her $18/month for haircuts for her husband who has dementia. She says the facility has been doing so for a couple of years. Mr. J is on Medicaid and the cost is being deducted from his trust account. In Illinois Medicaid residents receive $30.00 per month.
- Mrs. J had never received a phone call or any other notification of barbershop appointments for her husband, nor was she asked to consent to the haircuts.
- Since Mr. J has very thin hair that does not necessitate any special barbershop services, this charge seems excessive.

Our Case Examples
Hair Cut Case

The Law:

- **42 CFR 483.10(c)(8) and F162** assure that nursing homes not charge Medicaid and Medicare residents for items paid for by those programs.

- **42 CFR 483.10(c)(8)(i)(E)** states during the course of a covered Medicare or Medicaid stay, facilities may not charge a resident for the following categories of items and services:
  - Routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to, hair hygiene supplies, comb, brush, bath soap… hair and nail hygiene services, bathing, and basic personal laundry.

Our Case Examples
Hair Cut Case

The Law:

- **The SOM Interpretive Guidelines** for **F162** define hair hygiene supplies as comb, brush, shampoos, trims and simple haircuts provided by facility staff as part of routine grooming care.
- **F162** states that hair cuts, permanent waves, hair coloring, and relaxing performed by barbers and beauticians not employed by facility are chargeable. However, these charges are only permissible if the facility informs the resident that there will be a charge.
- All of Mr. J's subsequent hair cut maintenance and routine trims should be done by facility staff and he should not be charged.
- All outstanding charges were waived by the facility.

Our Case Examples

Weight Loss Case

The Facts:

- Mrs. F was admitted to the facility weighing 156 lbs; but now, 3 months later, she weighs only 89 lbs. The doctor noted in her file that she needed assistance with eating and needed a consultation with the dietician; however, the nurses note there is always a lot of food left her tray.
- When the Ombudsman meets Mrs. F, she is confused and asking for food. She states she is hungry.
- Mrs. F's weight loss during the first four months was 6.7% of her body weight.
- The Ombudsman is present when the annual survey is conducted.
- The Ombudsman strongly suggests that a survey team member speaks to Mrs. F.

Our Case Examples
Weight Loss Case

The Facts:

- When the surveyor asks if she is hungry, Mrs. F replies, “Yes, I am very hungry”.
- The surveyor reviews Mrs. F’s chart, which shows the continuous weight loss. She reviews several other residents’ records which also indicate significant weight loss.
- The final survey report contained 100+ pages of violations including untreated severe weight loss found in 15% of the residents.
- CMS decertified the facility, and issued a per day civil monetary penalty until all violations were corrected.
- Mrs. F is now at 94.4 lbs, able to hold a conversation, walk on her own, and eat on her own. She demands more food if she is hungry.

Our Case Examples
Weight Loss Case

The Law:

- **42 CFR 483.35(f)(1-4), SOM F368,** and the **Interpretive Guidelines** define nourishing snacks as offering of items, single or in combination, from the basic food groups. Adequacy is determined by resident interviews and evaluation of the overall nutritional status of residents in the facility.

- **42 CFR 483.25(i) and F325 and F326** assure the resident maintains acceptable parameters of nutritional status, taking into account the resident's clinical condition or other appropriate intervention, when there is a nutritional problem.

- The parameters of nutritional status which are unacceptable include unplanned weight loss.

Our Case Examples

Weight Loss Case

The Law:

- **SOM F326** contains a weight loss formula at % of body weight loss = the usual weight - actual weight/ usual weight x 100

- Loss of Body Weight

	Significant	Severe
In 1 month	5%	more than 5%
In 3 months	7.5%	more than 7.5%

- Calculation for Mrs. F:
  156 lbs-89 lbs =67 lbs/100=6.7%

Our Case Examples

Spicy Food Case

The Facts:

- Mrs. E is Mexican-American. She wants to eat spicy Mexican food, specifically jalapeño peppers even though her doctor tells her it is bad for her health. She signed a form acknowledging that she wants to eat spicy food even though she knows her doctor recommended against it.

- Mrs. E is well aware that her previous trip to the hospital was due in part to eating spicy food, but still insists she wants to eat the food. When asked if she would be satisfied with a milder pepper than jalapeño, she says no - she wants jalapeño.

Our Case Examples

Spicy Food Case

The Law:

- **42 CFR 483.10(b)(4)** and **F155 and** state the resident has the right to refuse treatment and the interpretive guidelines define treatment as care provided for purposes of maintaining/restoring health, improving functional level, or relieving symptoms.
- **42 CFR 483.15(a)** and **F241 and** require the facility to promote care in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.
- The **Interpretive Guidelines** require the surveyor to consider the resident's former lifestyle and personal choices including independence and dignity.

Our Case Examples

Spicy Food Case

- **42 CFR 483.15(b)(3) and F242** state that a resident has the right to make choices about aspects of her life in the facility that are significant to her and to exercise autonomy regarding things the resident considers important facets of her life.

Our Case Examples

Involuntary Discharge

The Facts:

- Mr. H was admitted to a long-term care facility that is certified for Medicare and Medicaid. He was admitted under Medicare, however, his Medicare days are running out. The facility states they do not have a Medicaid bed available so Mr. H needs to move out quickly.
- The facility did not issue the required 30 day notice to either Mr. H or his responsible party. The facility is certified to participate in the Medicaid program and is not a “limited bed” facility as allowed under certain state laws.
- The resident is Medicaid-eligible but the facility states they were no longer accepting Medicaid residents.
- The Ombudsman checked with the Medicaid State Office to confirm that all beds in the facility were certified.

Our Case Examples

Involuntary Discharge

The Law:

- **42 CFR 483.12(a)(2)** requires the facility to permit each resident to remain in the facility and not transfer or discharge unless:

  (i) it is necessary for the resident's welfare and the resident's needs cannot be met in the facility;

  (ii) 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 a stay in the facility; or

  (vi) the facility ceases to operate.

Our Case Examples
Involuntary Discharge

The Law:

- **42 CFR 483.12(a)(4)** requires that the facility notify the resident and, if known, the family member, surrogate, or representative of the transfer and the reasons for the transfer, and **42 CFR 483.12(a)(3)** requires the facility record the reasons in the clinical record.
- **42 CFR 483.12(a)(5)** requires the facility to give 30 days notice (except in an emergency situation).
- **42 CFR 483.12(a)(6)** The notice must include the reason for the transfer; the effective date; the location where the resident will be relocated; statement that informs the resident of the right to appeal the transfer; the name, address, and phone number of the State Long-Term Care Ombudsman.

Our Case Examples

Involuntary Discharge

- A resident can not be transferred for non-payment if she has submitted to a third party all necessary paperwork for the bill to be paid. Non-payment occurs only if Medicaid denies the claim.

- The **Interpretive Guidelines** state that conversion to Medicaid does not constitute non-payment so long as the facility has a certified Medicaid bed available.

Resources

- Code of Federal Regulations

  www.access.gpo.gov/cgibin/cfrassemble.cgi?title=200842

  Contains all Sections from 400 to the end

  - **Medicaid Regulations**

    http://ecfr.gpoaccess.gov/cgi

    Go to title 42-Public Health; Volume 4; Sections 430-599; Part 431

- State Operations Manual

  www.cms.hhs.gov/Manuals/IOM/list.asp

  Choose Publication # 100-07-State Operations Manual

- Long-Term Care Advocacy

  By Eric Carlson

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