From Admission to Care
Everything You Need to Know

Provided to you by
The Nursing Home Ombudsman Agency of the Bluegrass
3138 Custer Drive, Suite 110
Lexington, KY 40517
(859) 277-9215 or (877) 787-0077 Toll Free
(859) 272-0060 Fax
www.ombuddy.org

The Nursing Home Ombudsman Agency works to advance the rights of long-term care residents in the 17 county Bluegrass Area Development District.

Anderson, Bourbon, Boyle, Clark, Estill, Fayette, Franklin, Garrard, Harrison, Jessamine, Lincoln, Madison, Mercer, Nicholas, Powell, Scott, Woodford

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This booklet is intended to provide general information and is not intended to provide legal advice to residents or their families. For specific questions about any legal matter, consult your attorney or another professional legal service provider. You should never delay seeking legal advice, disregard legal advice, or commence or discontinue any legal action because of the information provided in this document.

A Note from the District Ombudsman

Dear Friends:

The Nursing Home Ombudsman Agency (NHOA) prepared this guide to help you and your loved ones become aware of the things you need to know and consider before deciding on a nursing facility placement.

Residents and families tell us that the first few weeks after moving into a nursing facility are perhaps the most challenging. We strive to ease the transition by providing the information in this guide.

The Nursing Home Ombudsman Agency of the Bluegrass (NHOA) has certified long-term care ombudsmen who regularly visit with residents to ensure all residents are treated equally, and their rights are respected. These ombudsmen are trained and certified to help residents and family members with problems or concerns.

Soon after admission we hope to connect with you so that we may provide additional information about residents' rights. When you have found placement in a nursing facility, please call us at (859)-277-9215 for the name of the ombudsman who serves that facility.

We would love to stay in touch with you. Visit us on the web at www.ombuddy.org. To receive our newsletter and other valuable information, call us and we will add you to our mailing list.

Denise Kennedy
District Ombudsman

Annual NHOA and Long-Term Care Statistics

In the Bluegrass there are 82 long-term care facilities and 5,200 residents.

Nursing home residents are, on average, 86 years-old. In Kentucky, 69% of these residents are recipients of Medicaid, and are therefore, by definition, low income. Women comprise 70% of residents. Approximately 12% of Kentucky nursing home residents are under the age of 65. Fifty percent of residents have been diagnosed with some form of dementia.

Each year, NHOA ombudsmen in the Bluegrass make over 6,000 site visits to long-term care facilities to monitor care and advocate for residents.

During these visits, NHOA ombudsmen identify, investigate, and work to resolve more than 1,500 complaints. These complaints include reports of abuse and neglect, poor care, injuries, falls, failure to respond to call bells, failure to follow doctor orders, pressure ulcers, and failure to notice a change in resident's condition.

NHOA regularly assists with Resident Councils and Family Councils. Only 33% of facilities in Kentucky have Family Councils.

Every year, NHOA helps thousands of individuals and families with nursing facility placement, care planning, and questions about rights, abuse, Medicare and Medicaid.

Residents in Bluegrass area long-term nursing facilities are from all across Kentucky, other states, and other countries.

An alarming statistic reveals that 60% of these residents have no regular visitor except their NHOA ombudsman.

By 2020, 12 million older Americans will need long-term care.

The Nursing Home Ombudsman Agency of the Bluegrass, Inc. (NHOA)

The mission of NHOA is to improve the quality of care for residents living in long-term care facilities. NHOA is an independent non-profit agency funded by donations and grants. NHOA's award-winning ombudsman program provides certified long-term care ombudsmen to advocate for residents in their home communities. Ombudsmen establish relationships with residents and families. Those relationships allow residents to feel loved and protected. Residents know they have an advocate on their side at all times. NHOA serves everyone regardless of age, race, ethnicity, religion, gender, sexual orientation, gender identity, national origin, and disability.

What is an ombudsman?

Ombudsman (om-buh dz-muh n) is a Swedish word for advocate. A long-term care ombudsman is an advocate for individuals and their families that need the services of a long-term care facility. Ombudsmen are trained to impartially investigate and resolve concerns of residents in long-term care facilities. They also provide information and refer residents to additional community resources when appropriate. The ombudsman is **not** an employee of the nursing facility or a government agency. *This means that your ombudsman works free of charge on your behalf*.

What can I expect from an ombudsman?

The ombudsman will regularly visit your family member in the nursing facility and provide education about residents' rights. The ombudsman is often the first person to become aware of a problem because **their complete focus is on the resident** and obtaining quality care and quality of life in a facility. With consent and confidentiality, the ombudsman investigates complaints on behalf of residents. Ombudsmen do not disclose the identity of residents or family members reporting complaints without consent unless they are ordered to do so by a court. The ombudsman is an advocate for residents and has the power, based on federal law, to intervene on their behalf. Upon receiving a complaint and consent, the ombudsman investigates the complaint, shares findings with the resident and/or their legal representative, and explains options for resolving concerns. Although, ombudsmen work to empower residents and families to advocate for themselves, they are always available to go forward on behalf of residents who cannot or do not want to address the problem alone. Ombudsmen understand the power imbalance involved in the resident to caregiver relationship, and will go to bat for residents. Ombudsmen follow up to make sure that problems are resolved, and solutions remain in effect.

Ombudsmen can guide families through the nursing facility system, and find answers to numerous questions about services, rights, benefits, and regulations. Just ask! The ombudsman can connect residents and families to the Family or Resident Councils. The ombudsman can accompany residents and families to care plan and other meetings with facility staff.

If a resident experiences abuse, neglect, or exploitation, the ombudsman can help report these incidents to state investigative agencies. In Kentucky, anyone who suspects abuse is required to report it to Adult Protective Services (APS) by calling their hotline 1-800-752-6200; this can be done anonymously if desired. The Office of Inspector General – Division of Health Care (OIG) is a state agency that regularly inspects or surveys facilities. OIG investigates to determine if facilities have violated state and federal regulations. Reports can be made directly to OIG at 1-502-564-7963, or NHOA can make reports on your behalf.

Is there an ombudsman in my area?

NHOA proudly serves 17 counties of central Kentucky referred to as the Bluegrass District: *Anderson, Bourbon, Boyle, Clark, Estill, Fayette, Franklin, Garrard, Harrison, Jessamine, Lincoln, Madison, Mercer, Nicholas, Powell, Scott, and Woodford.* There are ombudsman programs in all districts of Kentucky and in other states. Please call NHOA at 1-859-277-9215 for contact information of Ombudsmen in other areas.

Getting into a Nursing Facility

Do I need consent from my family member to place him or her in a nursing facility?

The first thing to do, if feasible, is to discuss the need for placement with the potential resident. It is not possible or ethical to force admission into a nursing facility or other long-term care facility against the will of a legally competent person, especially if they have decision-making capacity.

Once the issue of consent has been addressed, placement choices are dependent upon several determinations. These are:

- What will be the payment source initially and long-term?
- What level of care is the person seeking?

Families, chosen families, and loved ones may be tempted to make placement *against the wishes of the potential resident.* Families sometimes feel they must either coerce placement or conceal the true nature of placement. It is important to know that openness in relationships continues to be crucial even after a person reaches the physical and mental stage where they need nursing facility care. A resident may, in time, come to forgive a move to a facility that they perceive to be an action against them, but it is much more difficult to forgive such an action if it was based on false pretenses. Lying to someone initially builds a foundation of dishonesty which may make the entire nursing facility experience more difficult. Families should explain realistic options available to their loved one in light of current family, health, financial, and work situations.

It may be wise to talk with an ombudsman, social worker, or an attorney about the ultimate responsibility for decisions in the case of: legally competent adults *with decisional capacity*, legally competent adults who *lack decisional capacity,* and adults who have *given permission for others to make decisions* on their behalf. It is best if the potential resident can be involved in **all** family discussions about placement and for them to be actively involved in the decision-making process.

Discussions without the involvement of the potential resident can be very disturbing and make the adjustment to placement much more difficult. This is particularly true for persons with dementia, because they often hear portions of conversations and may interpret the content in a catastrophic manner.

For some people, nursing facility placement is their choice and a very positive experience. People who have been socially isolated, and/or in fragile health, often value the congregate setting and feel reassured to have nursing assistance available.

Are there options other than moving into a licensed long-term care facility?

Yes. Many individuals choose from a combination of in-home services, or a certified assisted living facility.

For more information and a listing of assisted living facilities contact the Department of Aging and Independent Living, a state agency that certifies assisted living facilities in Kentucky, at 1-502-564-6930 or visit http://chfs.ky.gov/dail.

A source of information for senior services and in-home services is The Bluegrass Area Agency on Aging and Independent Living or your local senior center. Their staff can advise individuals about senior centers, adult day care, family caregiver support programs, and homecare services. The Bluegrass Area Agency on Aging and Independent Living can be reached at (859)-269-8021, or toll free at 1-866-229-0018. Visit www.bgadd.org for a copy of the Pathways booklet, a comprehensive guide for older adults and their caregivers.

How do I find a placement for someone in the hospital?

For hospital patients, the ultimate responsibility for finding placement lies with the hospital or discharge planner. It is very practical to work with the discharge planner, to be as active as possible in the search for a facility, and to physically go to the chosen facility prior to placement. Since nursing facility beds are scarce in certain areas of Kentucky, there may be little genuine choice for consumers. Those being placed from hospitals, and using Medicare reimbursement are currently the most attractive prospects for nursing facilities.

Be Aware:

You may not have much say over the final nursing facility chosen if you have given the responsibility of finding the placement to the hospital.

The hospital has a strong financial incentive to make the placement.

Placement from a hospital is generally easier than from the community for several reasons:

- Often the nursing facility is able to access Medicare reimbursement for up to 100 days depending upon the diagnosis and progress of the resident. Some long-term care insurance policies only pay for a nursing facility stay after a hospitalization.
- The required admission paperwork (physical, diagnoses, assessments, etc.) usually accompanies someone from the hospital.

What is the process for moving from a home to a nursing facility?

The potential resident should make sure that all facilities they are interested in have a copy of their medical history, recent physical, as well as a list of medications and diagnoses. The potential resident must have been seen by their physician within 30 days prior to admission. You should politely badger the facility in order to keep your family member in the forefront. *Waiting lists can be a tool facility staff use to pacify families of Medicaid eligible residents. You should not rely on them as a means of finding admission to a facility.* The reality is, in Kentucky, nursing facilities essentially can pick and choose among applicants until they find those who best serve *their* needs.

Sometimes individuals focus on finding special care units for residents with memory disorders or behaviors that may be difficult for caregivers to manage. However, in most cases, there should be no need for placement in a special unit. Federal and state regulations call for individualized resident care plans and for the facility to adapt to the needs of the resident regardless of where he or she is located in the facility. ***Families should not have to pay a surcharge for the care required by the licensure and certification standards already in place.***

How can a resident move from one nursing facility to another?

If a person is in a licensed nursing facility, the responsibility of placement in another facility depends on who initiates the transfer.

Resident Initiated Move:

If the **resident** wants to move, the burden of finding the new placement rests with the resident, but *the social services department of the current facility is obliged to give assistance.* If a person is in a Personal Care Home or a Family Care Home, the administrator **may** give assistance, but is not required to do so. (See pages 23-24 for information on Personal and Family Care Homes.) Workers from the Department for Community Based Services are obliged to give assistance to residents wishing to relocate.

Facility Initiated Move:

If the **facility** is initiating the transfer *for any reason*, the burden for finding a new placement lies with the facility. All transfer and discharge rights may be exercised by the resident in this instance. Once the transferring facility has identified and secured a new placement, the resident may accept or refuse the transfer. ***If a resident is being asked to move, but does not want to please contact your ombudsman.***

Selecting a Quality Facility

LOCATION

- Is the facility close enough to visit on a regular basis?
- Will the facility be easy to reach during bad weather or an emergency?

PERSONAL PREFERENCES

- Will my loved one be comfortable with the room layout and décor?
- Are the residents dressed appropriately and well groomed?
- Do the residents appear to be comfortable and content?
- Are there other residents with similar interests or backgrounds?

HELPFUL SERVICES

- What therapies are offered by the facility?
- Is the ombudsman's information posted in the facility?
- Are there transportation services?
- Are there religious/spiritual services?
- Are the residents' rights posted in the facility?
- Is there a barber or beautician that can care for my loved one's hair?

Visit www.medicare.gov/nursinghomecompare to compare nursing facilities in your area.

ENGAGING ACTIVITIES

- Are planned activities posted?
- Does the facility offer activities that my loved one will enjoy?
- Can I visit some activities, and participate with the residents?

CARING STAFF

- Do I see the staff interacting with residents in a friendly and warm manner?
- Is staff available throughout the facility?
- Are the residents appropriately supervised by staff?

MEAL TIME

- Would the food be appealing to my loved one?
- Are the residents eating and enjoying their meals?
- Is staff available to help residents who need assistance eating?

APPROPRIATE SURROUNDINGS

- Is it clean and neat?
- Are there offensive odors in the air?
- Is it noisy because of loud voices, loud public address systems, or TV?
- Do I notice unanswered call lights?
- Do common areas look inviting and comfortable?
- Is there adequate space to meet residents' needs?
- Are the residents' rooms home-like and individualized?

ASK OTHER FAMILIES

- Is there an active Family Council at this facility?
- Are you able to ask other families what they think of the care here?

STATE INSPECTIONS

- Are the last three inspections available for your review?

Contact NHOA for a complete listing of nursing facilities in the Bluegrass District.

How Will I Pay for Long-Term Care?

Private Pay

Anyone who is not eligible for Medicaid or is not currently using Medicare benefits to pay for their care is considered private pay. Private pay residents may be using money from the sale of a home, savings, investments or monthly income to pay their bill at the nursing facility. In this instance, the family or potential resident needs to make an important calculation. If they want to enter a nursing facility, and *they do not need the service*, the question is: *Will they medically qualify for nursing facility placement when their money runs out and they need to apply for Medicaid?* If the person might run out of money before they become ill enough to qualify, continued stay might be threatened. Families may want to consider other community services or long-term care options until nursing facility placement becomes a physical necessity.

Residents who are private pay may also be utilizing their long-term care insurance policy benefits. There are no limits to what the nursing facility can charge private pay residents. There are also no limits to the basic services provided. It is important to request an itemized accounting of each bill.

Beds are *certified* to participate in the Medicare and/or Medicaid programs. Federal standards are used for this certification. When beds are *certified*, they can have the following designations:

- Nursing Facility (NF): contains beds which accept Medicaid payment.
- Skilled Nursing Facility (SNF): contains beds which accept Medicare payment; may also take Medicaid payment; usually called rehabilitation unit.
- Beds certified in both are called *dually certified* beds.

If the resident will need Medicaid coverage at some future point, the family needs to see if the facility has *certified* beds and if the bed the applicant is going to occupy is certified. Some facilities are totally certified for Medicaid; some are not. People with few resources should avoid facilities with few or no certified beds. It is illegal for the facility to directly inquire how much money an applicant has, but they will want to determine how long it will be until the resident becomes Medicaid eligible.

Medicaid

Medicaid is a state and federally administered insurance plan which can help an individual who requires long term care to receive nursing facility care in a Medicaid certified bed. In order to qualify for Medicaid, the resident must meet the Medicaid patient need criteria. Generally, Medicaid will act as a primary payor source after a resident has exhausted the skilled nursing facility care to which they are entitled pursuant to their Medicare coverage. Medicaid pays for skilled services and the lower intensity intermediate care. Medicaid also will cover Medicare deductibles and up to 14 bed hold days per calendar year.

Families can consult the Department of Medicaid Services web site for current information:
http://chfs.ky.gov/dms

If the person is going to use Medicaid benefits immediately and is physically in need of nursing facility care, there may be difficulties in finding placement. Families need to visit potential facilities, explain their need, and be open about finances. They should offer to cooperate fully in procuring the medical information necessary for admission as well as financial information necessary for Medicaid applications. It is illegal for a facility to discriminate against applicants for admission based on their source of payment, diagnoses, or disability.

Nursing facility services include room, assistance for daily living, dietary services, social services, nursing services, the use of equipment and facilities, medical and surgical supplies, laundry services, drugs ordered by the physician, and personal items routinely provided by the facility. Also included, if ordered by the physician, are X-rays, physical therapy, speech therapy, laboratory services, oxygen, and related oxygen supplies.

Who is eligible for Medicaid nursing facility services?

Individuals may be eligible if they meet the following requirements:

- Reside in a facility that participates in the Kentucky Medicaid Program and are placed in a Medicaid-certified bed.
- Require and meet the level of care for skilled nursing services, nursing facility services, and intermediate care services for the intellectually and the developmentally disabled.
- Are aged 65 years or older, blind, disabled, or currently Medicaid eligible.

Be Aware:

It is very important to be organized and have copies of all requested documents for your Medicaid appointment. Make sure that you keep a copy and receive a receipt of every piece of documentation you turn in in support of your application.

You may have to liquidate and spend down excess resources. For example, you may need to sell the second car, and prove you used the money on Medicaid allowable expenses.

What resources will be considered?

Medicaid may deny a resident's application if he or she has too much value in financial resources available to them. The resources of an individual residing in a nursing facility must be within Medicaid program guidelines. If an applicant is married, the resources of a resident's spouse are considered.

Resources are defined as cash money and any other personal property or real property that an individual or couple owns, or has the right, authority, or power to convert to cash. Resources include, but are not limited to, checking and savings accounts, stocks or bonds, certificate of deposits, automobiles, land, buildings, burial reserves, life insurance policies, and more.

Certain types of resources are excluded and are not considered in the Medicaid eligibility determination. These resources may include, but are not limited to, a home and adjoining land, household goods, personal effects, the first $1500 of a burial reserve, one automobile used for employment or to obtain medical treatment, burial spaces and plots, life estate interest in real property, IRAs and KEOGHs (under certain conditions).

The resident's home is considered an exempted asset for the first six months of the resident's facility stay if the total value is at or below $552,000. After the resident has been in the nursing facility for six months, Medicaid may request that the resident try to sell their home by listing their home for sale, or may request a statement that the individual intends to return to that home. Taking these steps will allow the home to remain exempt for another six months. If the home is sold, the money obtained will be considered an available asset and will disqualify the resident until that money is spent. If the individual intends to return home, the individual must provide a written and signed statement that they plan to return to the home, and it may be helpful that the individual estimate the number of months it will take to do so. Homestead property with an equity value less than $552,000 may also be exempted from consideration as an asset when a community spouse or certain other family members live in the home. To see if you qualify for this exemption, you will need to discuss the individuals who live in your home with Medicaid representatives.

Marital Status	Living Arrangement	Resource Limit
Single individual	Resident	$2000
Married couple	Both residents	$2000 each
Married couple	One member of the couple is a nursing facility resident; the other member of the couple remains at home	50% of joint resources but no less than $23,844 or more than $119,220

Financial Resources and the Community Spouse

Department for Community Based Services (DCBS) may complete an assessment of the combined countable resources of the nursing facility resident and the community spouse when requested by either spouse or an interested party representing the couple. The resource assessment, which may be completed without applying for Medicaid, involves

documenting and verifying all countable resources owned by the couple as of the date of the most recent admission of the resident to the nursing facility. After the resource assessment is completed, each member of the couple will be provided a copy of the assessment.

A single resident is allowed to keep **$2,000** in non-excluded financial resources. However, a community spouse (the spouse living at home) is allowed to keep 50% of couples joint resources, but no less than **$23,844** or more than **$119,220**. The resident and his or her spouse will have six months after application to take steps necessary to ensure the property is properly owned in order to have the property qualified for the resource exclusion. Staff at DCBS can offer guidance in this matter. Any money a couple has over these limits will be used to pay the nursing facility bill and can make the resident ineligible for Medicaid.

Transferred Resources and the "Look Back" Period

If a resident transfers resources to another person, it may adversely affect the resident's ability to obtain Medicaid. A transfer of resources is defined as cash, liquid assets, personal property, or real property which is voluntarily transferred, sold, given away, or otherwise disposed of at less than fair market value. **If resources are transferred 60 months prior to the Medicaid eligibility application month, it is presumed that the transfer of resources was for the sole purpose of establishing Medicaid eligibility.** A Medicaid applicant will still be penalized if the applicant gives the resource to a friend or family member, or to satisfy a gift given in his or her will. If the agency determines that a prohibited transfer of resources occurred, an ineligibility period may be established beginning with the month of the transferred resources.

There are a few exceptions to the transfer rule. A resident may transfer their home without penalty to the following persons:

- A spouse
- A child who is under age twenty-one or a disabled child of any age.
- A child who has lived with the resident and provided care for the resident for at last two years thereby avoiding institutionalization of the prospective resident.
- A sibling who has equity interest in the home and lived with the resident prior to institution for one year, and provided care for the resident.

The living arrangement must be documented with statements by two collateral sources such as, neighbor, physician, minister etc. Family members cannot be a collateral source.

Income Requirements

For the purposes of qualifying for Medicaid, Income is defined as money received from statutory benefits (Social Security, VA pension, Black Lung benefits, and Railroad Retirement benefits), pension plans, rental property, investments, or wages for labor and services. Income may be earned or unearned. If the nursing facility resident's net income is at or below $2,199 per month, the nursing facility resident is income eligible.

Persons with income in excess of **$2,199** can still qualify for Medicaid nursing facility coverage by placing all of their excess income into a Qualifying Income Trust (QIT). Legal assistance will be needed in order to draw up the trust. Only the income in excess of **$2,199** must be placed in the trust. Funds from the trust can be used to pay for the cost of the resident's care according to the terms of the trust.

Patient Liability

The portion of the nursing home bill a resident receiving Medicaid must pay is referred to as patient liability. Patient liability is determined by considering the resident's gross income and allowing a deduction of $40 for personal needs, an income allowance for a community spouse, health insurance premiums, and deductions for medical expenses approved by Medicaid. The remaining amount is the resident's patient liability, which is paid directly to the nursing facility.

How can I apply?
The Department for Community Based Services (DCBS) processes Medicaid applications for the KY Department of Medicaid. An application for Medicaid may be filed at your local Department for Community Based Services Office. DCBS implemented a regional processing concept and is seeking to move towards a state-wide processing goal. Information can be submitted in person at some of the local DCBS offices. **However, it is recommended that you begin the application process by contacting the Call Service number 1-855-306-8959 to request an appointment, ask questions, express concerns, or to check the status of your case.**

When you schedule your appointment at your local DCBS office, prepare for your application by gathering the following documentation:

○ Gross income (earned and unearned)	○ Deeds to any real estate
○ Certificates of Deposit	○ Health insurance
○ Life insurance policies (and cash-in value)	○ Medical bills
○ Prearranged burial arrangements or irrevocable burial trusts	○ Social security number
○ Broker's statement of investments (stocks, bonds, etc.)	○ Bank statements
○ IRAs and other annuities	○ Proof of identity (driver's license)
○ Proof of citizenship (birth certificate)	○ Other Resources

Note: This list is not all-inclusive; other documents may be required to complete an application for Medicaid eligibility.

Resource and income limits usually change each January because of income adjustments for inflation.

Medicaid covers nursing facility care in a Medicaid certified bed, and the resident must meet the Medicaid patient need criteria. Medicaid coverage only begins after the patient's Medicare coverage has ended. It pays for skilled services and the lower intensity intermediate care. Medicaid will cover Medicare deductibles and up to 14 bed hold days per calendar year.

What do I do if my application is denied?
Residents have the right to appeal Medicaid's decision to deny the resident Long-Term Care Coverage. Appeals must be filed within 30 days of the date on the denial letter. For assistance with appealing a Medicaid denial, you may wish to contact legal services. Legal Aid of the Bluegrass regularly assists residents with Medicaid denials. To contact Legal Aid of the Bluegrass, call 1-800-888-8189.

Medicaid Estate Recovery
If a resident receives Medicaid benefits during their lifetime, the State may seek to recover the costs of the medical care that Medicaid has paid for. This is called Medicaid Estate Recovery. Anyone who receives services in a nursing facility – or who receives home and community based services as an alternative to nursing facility care – is subject to this policy. Under certain circumstances, Medicaid Estate recovery may be waived. If you have questions about Medicaid estate recovery, you should contact an attorney.

The information above was correct at the time of printing. However, changes to the regulations can occur at any time. Consumers can consult the Department for Medicaid Services website for more current information. The web address is: www.chfs.ky.gov/dms/.

Medicare

This federal medical "insurance program" is available to some disabled younger persons and persons over the age of 65. It covers **skilled care for a short period of time for selected reasons**. When someone says, "She's skilled," they may mean: Medicare is paying the bill, or her care needs are intensive, or she resides in the section of the building called skilled, or any combination of these. **Part A covers facility charges; Part B covers health care provider services, outpatient care, durable medical equipment, home health care, and some preventive services; and Part D covers medication.**

Contacting Medicare:
For additional information about your Medicare plan, you can visit www.MyMedicare.gov or call 1-800-MEDICARE (1-800-633-4227).

Skilled care requires the services of skilled professionals such as registered nurses, physical therapists, occupational therapists, audiologists, etc. You must require the professional services on a daily basis, and the services must be of such a nature that they can only be provided to you as an in-patient nursing facility resident.

- *Benefit period* is the way Medicare measures the use of days in the hospital and in a Skilled Nursing Facility (SNF). For a hospital in-patient stay, the first 60 days are covered by Part A which picks up all covered services except for the Part A deductible which is currently $1,260.
  - If there is an extended stay (past 60 days), days 61-90 have a co-insurance of $315 a day.
  - A stay longer than 90 days is eligible for life-time reserve days. A beneficiary has 60 life-time reserve days to be used for stays longer than 90 days. These can be used for one day or used all at once. Co-insurance for these days is $630.
- Sixty days must pass between a discharge and a readmission for the beneficiary to be in a new benefit period. The hospital cannot bill the deductible unless the person is in a new benefit period.
- For the first 20 days in a nursing facility, Part A picks up all covered services. For days 21-100, there is a co-insurance which is currently $157.50 a day.
  - The resident has to pay the co-insurance using Medicaid, Medigap insurance, or cash. A day is counted when the resident is there for the midnight census.
  - If readmission **occurs within** 30 days of discharge from the SNF, the SNF benefit period picks up right at day of discharge. If there is a readmission **after 30 days**, there must be a three-day hospital stay, and then there is a renewal of SNF benefits.
  - The qualifying three-day hospital stay expires if long-term care is not used within 30 days of hospitalization.

Can Medicare pay for custodial care?

Medicare does not pay for custodial care, which is helping your loved one with activities of daily living. Examples are: getting in and out of bed, eating, bathing, dressing, and toileting. It may also include treatments that individuals cannot do for themselves such as eye drops, managing colostomy care, or bladder catheters.

MEDICARE PART B

When the beneficiary in a Medicare-certified SNF is not entitled to Part A benefits, limited benefits are provided under Part B. The following services may be billed by the SNF or the rendering provider or supplier under an arrangement with the SNF include, but are not limited to, diagnostic laboratory tests, x rays, hospital outpatient services, ambulance services, rehabilitation services, the purchase and rental of durable medical equipment, orthotic/prosthetic devices, and surgical dressings

What if Medicare will not pay for a therapy that my loved one really needs?

If a resident is told that Medicare will not pay for a particular therapy, the resident has the right to (and indeed should) ask the facility to submit a *demand bill* to Medicare. This means that the denial of benefits will be reviewed by an outside, impartial medical person. Medicare will make the determination to uphold or reverse the facility opinion. They have three days to do this, and the resident is not obligated to pay for those three days regardless of the Medicare determination. If the determination goes against the resident, the resident can appeal it through a formal appeals process. If the resident loses the appeal, they will have to pay the bill if the original Medicare determination is upheld.

It is important to note that if Medicare stops paying for a particular therapy it does not necessarily mean that the resident no longer needs the therapy. It may mean that the *cap* for therapy has been met for that individual. The resident may still need therapy. The family and/or resident needs to be told that they will be billed for the therapy, and they must be told what it will cost before the service is rendered.

MEDICARE PART D:

The facility can provide residents with information about enrolling in Medicare Part D and inform them about which prescription drug plans include the pharmacy the facility uses. Generally, the resident or their legal representative must actually select the plan. Residents who are dually eligible for both Medicare and Medicaid and who do not select a plan will be randomly enrolled in a plan without regard for how well the plan covers what the resident needs. It is important for residents to choose a plan that will cover the drugs they are taking from a pharmacy that contracts with the facility in which they are residing. Unlike those in the community, persons living in nursing facilities will be allowed to change plans every 30 days in order to maximize their coverage.

How can I appeal a Medicare denial to pay for services?

To file an appeal, ask your physician or health care provider for any information that may help your case.

- If you have a Medicare Advantage Plan, look at your plan information, call your plan, or go to www.medicare.gov to learn how to file an appeal.
- If you have Original Medicare, you can get the **Medicare Summary Notice (MSN)** that shows the item or service you are appealing. Your MSN is the statement you get every three months that lists all the services billed to Medicare and tells you if Medicare paid for the services.
    - Circle the item(s) on the MSN you disagree with and write an explanation on the MSN of why you disagree.
    - Include your telephone number, Medicare number, and sign the document. You may want to keep a copy for your own records.
    - Send the MSN to the Medicare contractor's address listed on the MSN. You can include any additional information about your appeal.
    - You must file the appeal within 120 days of the date you get the MSN. If you want to file an appeal, make sure you read your MSN carefully and follow the instructions.
- **Contact your State Health Insurance Assistance Program (SHIP) if you need help filing an appeal.**
    - Call: 1-877-293-7447 or visit: http://chfs.ky.gov/dail/ship.htm

What to Expect on Moving Day

Will I have to sign a contract?

An admission contract is a legal document that describes the relationship between the nursing facility and the resident. The agreements made in this contract are significant, because these agreements outline the services the facility provides, the rights and responsibilities of the resident, and the charges for care. **This is a legal document; therefore, it is crucial that you read and understand this document before signing it.** Remember that the facility drafted this contract and took care to ensure it protects the interests of the institution first. Some admission contracts contain unenforceable clauses that attempt to mislead residents into thinking that they have fewer rights than they actually have, and that the facility has fewer responsibilities than it actually has. Ask for and obtain a copy of the signed contract before you leave the building.

At the time of admission, the resident must be fully informed through clear written and verbal language of all services available. A copy of these services with the resident's signature must be kept by the facility in the resident's file. Information regarding residents' rights and contact information for the local ombudsman must also be provided.

Protecting Your Rights:

When entering a nursing facility, you do not have to sign papers that require **mandatory arbitration** in the event of a dispute with the nursing facility. ***You can ask that any arbitration provisions be stricken from the contract prior to signing.***

Be Aware:

By law a nursing facility must not require another person (commonly known as "responsible or third party") to guarantee payments as a condition of a resident's admission or continued stay.

Will I have to pay a deposit?

Persons seeking placement in a nursing facility are often required to put up large deposits in order to be admitted. A facility may require a cash deposit before admission if the care will not be covered by Medicare or Medicaid. It is unlawful for a facility to require a cash deposit of any person covered by Medicare, or Medicaid. Federal law prohibits facilities from requiring pre-payment as a condition of admission for care covered under either Medicare or Medicaid.

The facility may request that Medicare beneficiary pay co-insurance amounts and other charges for which a beneficiary is liable. These should be paid as they become due but not in advance.

A nursing facility may not require a deposit from persons who demonstrate proof of their eligibility for Medicaid. If a resident is applying for Medicaid, but a determination of eligibility has not been made has not been made, the facility may collect a refundable security deposit. If the resident is later determined to be eligible for Medicaid, the facility must refund the deposit prior to billing Medicaid. A facility cannot require a third party guarantor for a Medicaid eligible applicant as a condition of admission.

What type of emotional reaction can we expect from our loved one?

A move into a nursing facility is a life changing event. The resident may experience feelings such as abandonment, anger, and depression. Families may experience a range of emotions including regret, guilt, doubt, and frustration. Encourage your family members to discuss their feelings. The ombudsman, along with facility staff, may be a helpful resource in easing the adjustment process.

Once the individual moves into the nursing facility, remember to give them time to adjust to their new surroundings. Spending extra time with the resident in the beginning can help to ease the transition and relieve feelings of abandonment. When at all possible, include the resident in any decisions that need to be made in regards to their care, visitors, outings, and furnishings of their room.

How can I protect his or her personal belongings?

When taking personal belongings into the nursing facility, be sure to label each item including clothing. Even if the family launders clothes for the resident, clothing can sometimes be put into the facility laundry by mistake. There should be a personal inventory at the nurses' desk for each resident. This is a list of items that belong to the resident including hearing aids, televisions phones, and any personal furnishings. Be sure when you take something new into the facility to **add that item to the list**. You also need to remember to **remove from the list** any item that is taken out of the facility to keep the list accurate.

Remember:

Generally, it is useful to think about how close a potential facility is to the family members who will be providing support. Ultimately, a facility close to family may be more desirable than one far away regardless of differences in the quality of care or the attractiveness of the facility. If families are close to facilities, they might visit more often and can support the resident in his or her quest for quality care and quality of life.

You might consider taking a picture of personal items as a record in case of loss. This can include a photograph (with permission) of the resident wearing their dentures, hearing aids, glasses, sitting in their own wheelchair, or covered in their favorite hand-made quilt.

Hearing aids have a serial number that can be recorded in the resident's chart. Some styles of hearing aids such as those worn behind-the-ear can be fitted with a chain and clip that attaches to a shirt collar to help prevent loss. Dentures can be engraved. Your personal dentist can probably do this for you. It's easiest to have the engraving done at the same time the dentures are being made; however, the dentures can be engraved at a later date.

Can we personalize the room?

Because most residents have a roommate, there is not a lot of room for personal belongings. Yet, it is important to personalize the room to make it homelike. This can be accomplished by bringing a small bookcase, side table, comfortable bedside chair, photographs, clock radio, pillows, and personal toiletries.

Rather than placing an original family photograph in the resident's room, make a copy that can be more easily replaced if lost or damaged.

Regardless of the measures taken to prevent theft, it does occur. It is best to keep expensive or sentimental belongings, such as jewelry, with family members or in a safe place outside the facility, or to ask for a lock box or lockable bedside drawer.

Nursing Home Ombudsman Agency of the Bluegrass, Inc.

Nursing Facility Staff

Below are some of the common positions and duties within a nursing facility:

- **Activities Director:** Directs activities for residents including group events or in-room activities.
- **Activities Assistant:** Assists the activities director in helping residents participate in varying activities within the facility.
- **Administrator:** Responsible for running the nursing facility, supervising staff, and communicating with families.
- **Beautician/Barber:** Provides hair salon services to residents. This person often works under a contract with the facility and sets the rates for services.
- **Business Manager:** Manages resident accounts and billing.
- **Kentucky Medication Aide (KMA):** An aide that is certified to dispense medications to residents.
- **Dietary Manager:** Manages the kitchen of the facility.
- **Dietitian:** Oversees the nutritional needs of each resident. Some facilities contract with dietitians to provide this service and the dietitian makes periodic visits to the facility.
- **Director of Nursing (DON):** Supervises nursing staff and nursing needs of residents. The DON is also a Registered Nurse (RN).
- **Head of Housekeeping:** Manages the housekeeping department, cleanliness of the facility, and laundry services.
- **Head of Maintenance:** Oversees the maintenance of the facility.
- **Licensed Practical Nurse (LPN):** Works under the direction of the DON, supervises State Registered Nurse Aides, and gives direct care to residents.
- **Medical Director:** Physician responsible for the medical care of all residents. The physician is required by law to visit the resident once in a three-month period. Some physicians make use of physicians' assistants and/or a nurse practitioner.
- **Occupational Therapist:** Works with residents to fit them with assistive devices such as wheelchairs, positioning cushions, walkers, etc.
- **Physical Therapist:** Gives intensive help with physical movement through a program of exercises.
- **Restorative Therapist:** Works under the supervision of the physical therapist to provide range-of-motion exercises to residents.
- **Social Worker:** Helps residents and families with any personal concerns including problems within the facility, financial concerns, psycho-social needs, as well as helping with obtaining needed medical devices like hearing aids, glasses, dentures, and wheelchairs. If a facility has more than 120 beds, this must be a certified social worker.
- **Speech Therapist:** Trained to help individuals with speech and swallowing problems.
- **State Registered Nurse Aide (SRNA):** Gives direct care to residents under the supervision of the nursing staff including bathing, feeding, and dressing.
- **Unit or Charge Nurse:** Works under the supervision of the DON and is usually responsible for the care of residents and supervision of nursing assistants for a particular area, hall, or unit in a nursing facility.

Contact Your Ombudsman:

Your nursing facility ombudsman can be a good source of information about the workings of the facility. Your ombudsman can help you identify who the *change makers* are in your facility so you don't spin your wheels addressing complaints with the wrong staff person.

Resident Care Requirements in Nursing Facilities

Most residents require some help with basic needs such as bathing, dressing, eating, and toileting. The nursing facility **must** identify each resident's needs and establish a Care Plan to meet these needs. The information below describes some of the requirements nursing facilities must meet in helping residents with daily care.

What will be in the care plan?

A care plan determines how the staff will help a resident with individual needs and preferences. Care plans are reviewed on a regular basis to make sure they work, and they must be revised as needs change. Care plans are developed during the care planning conference and then revised every three months.

Staff, residents, family, and/or the resident's chosen representative talk about life in the facility during the conference. You can bring up problems, ask questions, or offer information to **help staff provide individualized care**. Be sure to talk about what the resident needs and how he or she feels. This is a good time to discuss medications, personal care, staff, activities, exercise, therapies, food, and restraints. Residents can review their medical and care records prior to the care plan conference.

A good care plan should:

- ❖ Be specific, individualized, and written in language that everyone can understand.
- ❖ Reflect the resident's interests as well as needs and support the resident's well-being, functioning, and rights.
- ❖ Use a multi-disciplinary team approach and use outside referrals as needed.
- ❖ Be re-evaluated and revised every three months.

If requested, the ombudsman may attend with the resident, or they can assist in preparing for the meeting.

Are there federal and state standards of care?

The Federal and Kentucky Nursing Home Reform acts and regulations set daily care requirements for nursing facilities. Kentucky law applies to all Kentucky nursing facilities. Federal law only applies to Medicare and Medicaid-approved nursing facilities. Almost all Kentucky nursing facilities are Medicare or Medicaid-approved.

Federal law contains four key standards for nursing facility care:

1. The nursing facility must provide services to help each resident attain or maintain the **highest practicable** physical, mental, and psycho-social well-being.
2. A resident's ability to bathe, dress, groom, transfer, walk, toilet, eat, and communicate **must not decline** unless it is medically unavoidable.
3. If a resident is unable to carry out activities of daily living, he or she **must receive help** to maintain good nutrition, grooming, and personal and oral hygiene.
4. Each resident has the **right to make choices** about his or her care.

Besides these general principles, Kentucky and federal laws set minimum requirements for daily care. Some of these requirements are described below:

General Hygiene

Assistance should be provided for any resident that needs help with general personal hygiene including: skin, oral, and hair care. Residents should also have the opportunity to shave daily with assistance if needed. Residents should receive help to take a full bath or shower as often as needed.

Pressure Sores

Residents who lie or sit in one position for long periods of time often develop pressure sores, also known as bed sores. Pressure on the skin prevents blood vessels from carrying nutrients to the affected area. This causes skin breakdown which can lead to large sores, infections, and severe pain if not treated. Poor nutrition and certain conditions may also lead to development of pressure ulcers.

Residents confined to a bed or a chair should be checked and their position changed (turned) every two hours or more often if the resident is uncomfortable. If needed, supportive devices, special mattresses, pads, and pillows should be used to maintain normal body posture and to relieve pressure. Residents should receive daily help with walking and exercise to help maintain or improve their circulation, strength, and use of the body.

Dressing

Residents should be dressed in their own clean, comfortable clothing each day. Residents who walk should wear appropriate footwear, and non-ambulatory residents should have suitable foot coverings when out of bed.

Toileting

Residents who have control of their bowel and bladder should receive help using the toilet as often as needed. However, some residents are incontinent, meaning they have lost control of their bowel or bladder. If this is the case, those who become wet or soiled should be cleaned and changed quickly. Incontinent residents should receive care to restore as much normal bowel and bladder functioning as possible.

Eating

Residents who need help eating should receive appropriate assistance during meal time. They may need packages opened or special eating utensils provided. In some cases, residents may require help feeding themselves. Food normally eaten hot should be served hot, and food normally eaten cold should be served cold.

Fluid Intake

The nursing facility must ensure that each resident receives sufficient fluids to maintain good health and prevent dehydration. Fresh water and drinking cups must be available on each bedside table.

Vital Signs

Upon admission residents must be weighed, have blood pressure, temperature, respiration rate, and pulse taken. These should be taken at least monthly or more often if ordered by a physician.

Families should:

- Support your resident's agenda, personal choices, and participation in the care plan meeting.
- Even if your resident has dementia, involve him or her in care planning as much as possible. Always assume he or she may understand and communicate at some level. Help the staff find ways to communicate with your resident.
- Get a copy of the care plan. Monitor the care plan and talk with staff if questions arise.

Special Needs

Nursing facilities must arrange for any special services residents may need such as physical therapy, speech therapy, occupational therapy, dental services, mental health evaluation and treatment, podiatry services, respiratory care, and vision and hearing services.

This guide summarizes some of the daily care requirements nursing facilities must meet. Many other requirements also exist. If you have specific questions about care requirements in Kentucky nursing facilities, please contact our office at (859)-277-9215.

Relationships between Residents, Family, Chosen Family, and Friends

- **Guardian:** A Guardian is appointed by the court after a jury trial has been held to determine mental competency based on medical evidence and testimony of a social worker. The person whose competency is in question is required, if able, to appear in court. The state or an individual may be appointed Guardian. The finding of incompetence results in the removal of all of a person's adult rights. The law refers to this as being *disabled.*

For information about guardianship:

- Visit http://kypa.net/Guardianship.html
- In Lexington call the Fayette District Court at 859-246-2240

- **Limited Guardianship:** Limited guardianship is determined through the same procedure as a Guardian. It is used when a person is unable to make decisions related to personal care. Only *personal care rights* are granted to the Limited Guardian by the court.

- **Conservator:** A Conservator may be appointed to handle the resident's finances if the court finds that the resident is unable to handle his or her financial affairs but is capable of making his or her own personal care decisions.

- **Power of Attorney:** Power of attorney (POA) may be voluntarily appointed by an individual to another person known as the Attorney-In-Fact (AIF). A person should not appoint anyone his or her AIF unless they totally trust the AIF. Powers of attorney are generally used for handling specified tasks and financial affairs such as paying bills, depositing checks, etc. Authority ceases when the individual becomes mentally incapacitated unless the POA is a *durable* POA.

For information about power of attorney call Access to Justice at 1-800-200-3633 or Legal Aid of the Bluegrass at 1-800-888-8189.

- **Durable POA:** Durable POA differs from a regular POA. It specifically states that **authority continues despite disability.**

- **Interested Family Member:** Interested Family Member (IFM) is a designation assigned by the nursing facility to someone on behalf of a resident. This is usually a family member, or close friend of the resident. IFM may be asked by the nursing facility to make certain decisions regarding the resident's care, etc. and to do things for the resident like purchase clothing, etc**. This is not a legal designation**. The IFM or the resident may terminate the relationship at any time.

- **Next of Kin:** Next of Kin includes the closest relative of a resident. No legal obligation is implied.

- **Representative Payee:** The person or nursing facility designated by the Social Security Administration (SSA) or Veterans' Administration (VA) to receive a benefit check on behalf of another person. For example, a check for James Smith is paid to Lucy Jones, and Lucy pays the facility. Or, the benefit check can go directly to the facility if the facility is the payee. The designation may be altered by requesting a change at the SSA or VA office.

Contact the Social Security Administration:
If you have questions about your social security benefits, call 1-800-772-1213 or visit: www.ssa.gov.

For information about your health care benefits through the VA, call U.S. Department of Veterans Affairs 1-877-222-8387 or visit: www.va.gov.

The Right to Care without Discrimination

Do civil rights laws apply to nursing facilities?

Almost all Kentucky nursing facilities participate in the Medicare or Medicaid programs. To do so, these facilities have agreed to not discriminate against people seeking care on the basis of race, national origin, age, religion, sex, color, or physical or mental disability. Kentucky law, which covers all nursing facilities in Kentucky, also prohibits certain other types of discrimination.

What can I do if discrimination occurs?

If you believe your loved one has experienced discrimination due to race, color, national origin, age, sex, handicap, or religion by a Medicare or Medicaid-approved nursing facility, you may file a complaint with the Office for Civil Rights. The Office for Civil Rights is a division of the United States Department of Health and Human Services (DHHS). It is responsible for making sure that all organizations receiving federal funds from DHHS comply with the civil rights laws.

If the Office for Civil Rights investigation confirms you were discriminated against, it will negotiate with the nursing facility to correct the discriminatory action. For example, if you were improperly denied admission, the facility may be asked to admit you and publicize to the community that it will not discriminate against future applicants. If the nursing facility does not agree to take corrective action, the Office for Civil Rights may seek to suspend or terminate federal funding to the nursing facility. The Office for Civil Rights will send you a report on its findings and actions taken to correct the problem.

Your complaint must be in writing. If you prefer, the Office for Civil Rights can send you a Discrimination Complaint Form to assist you in completing the complaint.

When you write your complaint to the Office for Civil Rights, include the following information:

- The name of the person being discriminated against, address, and telephone number. You must sign your name to the complaint letter.
- Name and address of the facility you believe discriminated against you.
- How, why, and when you believe the discrimination took place.
- Any other relevant information.

Send your complaint, or request a complaint form from:
Department of Health and Human Services
Regional Manager for Civil Rights
Atlanta Federal Center
62 Forsyth Street SW, Suite 3B70
Atlanta, GA 30303-8909
www.hhs.gov/region4
1-404-562-7886
1-404-331-2867 TDD/TTY

Restraints

What are physical restraints?

Physical restraints are items used to restrict, restrain, or prevent movement of a person. Examples of restraints include belts, vest restraints, cuffs, and sometimes special chairs or bed side-rails. *If an item is used to restrict movement, it is a restraint.* The same item may not be considered a restraint if it is used to enable a resident in some way. For example, a bed rail could be used to keep someone from getting out of bed or could be used to help a resident turn over in bed.

What are chemical restraints?

A chemical restraint is the use of a drug to control an individual's behavior and is appropriate only if it is used to ensure the physical safety of residents or other individuals. Chemical restraints may be prescribed because a facility perceives the resident as being a *behavior problem*. These drugs are often referred to as psychotropic medications. The plan and use of psychotropic drugs must be periodically reviewed. These drugs are inappropriate if:

- The dose is too high
- Appropriate dose reductions are not followed
- There is unjustified chronic use
- There is no documented benefit to the resident
- The wrong type of drug is given for a particular diagnosis
- As an unnecessary duplicate drug therapy

Restraints must never be used as a:

- Permanent means of control.
- Form of punishment.
- Convenience for the facility staff.
- Substitute for activities or treatment.

Can restraints have a negative impact on a resident?

Although restraints may help prevent some injuries, they often create other serious problems. These may include chronic constipation, incontinence, pressure sores, emotional problems, isolation, and loss of the ability to walk or perform other activities. Residents may also be harmed trying to escape from restraints or from improperly applied restraints. If you have concerns or questions about the use of antipsychotic medications or medication featured on the Beers Criteria for Potentially Inappropriate Medication Use in Older Adults, please call the Ombudsman 859-277-9215.

What are the rights of nursing facility residents regarding the use of restraints?

Nursing facility residents have the right to refuse treatment, including the use of restraints.

What are federal guidelines regarding restraints?

Federal and state laws prohibit nursing facilities from using restraints unless they are medically needed. If restraints are used, *they must be based on a physician's order for a specified and limited time*. Physical restraints may only be applied by a qualified professional. Facilities must ensure that a resident's abilities do not decline unless the decline cannot be avoided due to the resident's medical condition. Residents often lose the ability to bathe, dress, walk, toilet, eat, and communicate when they are regularly restrained. If restraints are necessary, they must be used in a way that does not cause these losses. Residents must be released from physical restraints and repositioned at least every two hours.

Nursing facilities sometimes use restraints to help keep residents in proper body alignment or position. However, proper positioning can often be achieved by using pillows, pads, or comfortable chairs.

How can I help prevent unnecessary restraint use?

Make sure the nursing facility conducts a careful assessment and considers all options before using restraints. If your nursing facility knows you are well-informed on this issue, they are more likely to respect your wishes regarding use of restraints. If you need further assistance, contact the Nursing Home Ombudsman Agency of the Bluegrass.

Resident's Rights Overview:

- be fully informed including:
  - advance notice of plans to change their room or roommate
  - access to state survey reports
- participate in their own care including:
  - their treatment, care and discharge planning
  - refusal of medical treatment
- make independent choices including:
  - what to wear and how to spend their free time
  - use of own physician
- privacy and confidentiality including:
  - privacy in treatment and care of personal needs
  - private and unrestricted communication with any person of their choice
- dignity, respect and freedom including:
  - treatment with the fullest measure of consideration, respect and dignity
  - free from mental and physical abuse, punishment, seclusion and restraint
- security of possessions including:
  - managing own financial affairs
  - right to file a complaint with state survey and certification agency for abuse, neglect or financial exploitation
- transfers and discharges including:
  - a 30 day notice for transfer or discharge from the facility
  - notice must include reason, effective date, location to which the resident is transferred or discharged, right to appeal, state long-term care ombudsman information
- complain including:
  - presenting grievances to staff or another person without fear of reprisal
- have visitors including:
  - immediate access by relatives and others subject to reasonable restrictions with the resident's permission

How Nursing Facilities Can Protect Residents' Rights:

- Educate residents and their families about their rights.
- Educate and sensitize every level of staff about residents' rights.
- Incorporate resident participation and self-determination into every aspect of nursing facility service (resident advisory committees for food services, activities, housekeeping, etc).
- Provide more support to workers including sufficient staffing ratios and training, better supervision, dignified working conditions, and increased salaries and benefits.
- Orient aides to the residents with whom they will work and promote relationship-building between staff and aides.
- Use the information and wisdom of residents and their representatives to help develop and conduct training programs for staff.
- Help staff, residents, and families overcome the tension between dependence and empowerment; residents need assistance, but the help they receive should increase their ability to help themselves.
- Establish a grievance committee composed of residents, family, and staff representatives as well as administration.
- Encourage and promote an open exchange of ideas, recommendations, and concerns throughout the facility among residents, families, staff, and administration.
- Build more private rooms for individual residents and public rooms for private use by residents as needed.
- Promote a sense of community within the nursing facility, for example, by organizing activities for each wing and each floor; designing activities that promote interaction and intellectual and emotional stimulation.

Levels of Long-Term Care in Kentucky

	ASSISTED LIVING	FAMILY CARE HOMES	PERSONAL CARE HOMES	NURSING FACILITY	SKILLED NURSING FACILITY
Type of Care	Community Housing	Community Housing limited to 2-3 residents; managed by an owner-operator	Community Housing-may have professional staff; must have state approval to open these; usually many residents	Care needs determined by assessment; still called *intermediate care* by some; insurance calls this level *custodial care*	Care needs determined by assessment; usually involves therapies; AKA sub-acute, rehab, extended care
Licensing	None	State license	State license	State license	State license
Certification	Required	None	None	Federal, if Medicaid beds	Federal, if Medicaid or Medicare beds
Residents Rights	Ordinary citizen rights	State rights except for transfer and discharge	State rights, including transfer and discharge	All state and (federal-if participating in Medicaid) rights including transfer and discharge.	All state and federal rights including transfer and discharge
Living Space	Independent apartments; features locked doors, private toilet and shower	In a private home; usually shared bedroom; access to all living space in the home	Limited to number of beds applied for by the owner and granted by the state; usually shared bedrooms with congregate living space	Limited to number of beds applied for by the owner and granted by the state; residents share rooms; a few private rooms are available; congregate living space	Limited to number of beds applied for by the owner and granted by the state; residents share rooms; a few private rooms are available; congregate living space
Personal Services	24 hour non-professional supportive services (can receive assistance with ADLs, i.e., bathing, eating, dressing, grooming, toileting, transferring, and self administration of medications)	Non-professional supportive services-24 hour supervision; can receive assistance with ADLs, i.e., bathing, eating, dressing, grooming, toileting; must be mobile or mobile non-ambulatory	Non-professional supportive services-24 hour supervision; can receive assistance with ADLs, i.e., bathing, eating, dressing, grooming, toileting; must be mobile or mobile non-ambulatory	Professional and supportive services; small facilities can contract for services	Professional and supportive services; therapies often by outside contractor

	ASSISTED LIVING	FAMILY CARE HOMES	PERSONAL CARE HOMES	NURSING FACILITY	SKILLED NURSING FACILITY
Health Services	By contract with outside entity	No professional staff; home health may be used	No professional staff required; may be available or by contract from home health	RN 1 shift per day, 7 days per week; other staff to meet the needs of residents	RN 1 shift per day, 7 days per week; other staff to meet the needs of residents
Inspection Schedule	Annually by the Office of Aging	Annually by the Office of Inspector General (OIG)	Annually by OIG	9-15 month schedule by OIG; federal inspection possible	9-15 month schedule by OIG; federal inspection possible
Oversight	Department of Aging & Independent Living (DAIL)	Every six months by the Department for Community Based Services (DCBS)	Every six months by DCBS	DCBS if abuse, neglect, or exploitation is alleged	DCBS if abuse, neglect, or exploitation is alleged
Complaints	DAIL for services, DCBS if abuse, neglect or exploitation is suspected	OIG for regulatory violations, DCBS if abuse, neglect or exploitation is suspected, Ombudsman for any complaint or suspected rights violation	OIG for regulatory violations, DCBS if abuse, neglect or exploitation is suspected, Ombudsman for any complaint or suspected rights violation	OIG for regulatory violations, DCBS if abuse, neglect or exploitation is suspected, Ombudsman for any complaint or suspected rights violation	OIG for regulatory violations, DCBS if abuse, neglect or exploitation is suspected, Ombudsman for any complaint or suspected rights violation
Payor Source	Private funds	Private funds; State supplementation; VA contracts	Private funds; State supplementation; VA contracts	Private funds, Medicaid, VA contract, insurance	Medicare, insurance private funds, Medicaid, VA contract
Ombudsman Services	No, except for information and referral when requested	Yes	Yes	Yes	Yes
Notes	Lease agreements or the contracts are key in this setting; only services agreed to in the contract and paid for per contract will be given; services offered may vary; required to help clients find appropriate living arrangement upon giving them a move out notice.	Residents may have a Medical card (Medicaid) but this does not pay for their stay in the facility	Residents may have a Medical card (Medicaid) but this does not pay for their stay in the facility	Care plans are a crucial piece to receiving quality care	Care plans are a crucial piece to receiving quality care; even if this is a unit in a hospital, it is still a nursing facility

Donating to the Nursing Home Ombudsman Agency

Love is Ageless – Support Resident Advocacy

Since the Nursing Home Ombudsman Agency (NHOA) is a nonprofit organization; we rely on your financial support to continue our ongoing advocacy for long-term care residents. Each day, NHOA ombudsmen provide advocacy services to individuals in nursing facilities in the 17 counties of the Bluegrass district. A $100 donation provides a year's worth of ombudsman services for a single resident. All levels of giving are truly appreciated and help to ensure our continued efforts to make the nursing facility experience a positive one for our Bluegrass residents.

How can I make a donation to NHOA?

Check or Money Order

Please mail checks made payable to the Nursing Home Ombudsman Agency at 3138 Custer Drive, Suite 110, Lexington, KY 40517.

Cash

To make a financial donation to NHOA in cash, visit our office at 3138 Custer Drive, Suite 110, Lexington, KY 40517.

Credit Card

We are able to accept credit card donations on our website at www.ombuddy.org. Look for the Donate Now button. Your payment information is 100% secure.

Planned Gifts

A planned gift is legally arranged during your lifetime. Planned gifts take many forms, providing additional income for you and/or your heirs, reducing income and estate taxes, allowing you to fulfill your personal, financial, and charitable goals. Planned gifts can be made in cash, real estate, stocks, bonds, personal property, or life insurance.

Remember a Loved One

Many friends of NHOA choose to donate to NHOA in memory or honor of a friend, relative or colleague. When making a memorial or honorary contribution, please tell us:

- Name of the deceased or honored person.
- Your name, address and phone number.
- Name and address of deceased person's family member or name and address of the person you wish to honor, so we can notify them of the gift.

Bequests

Naming NHOA as a beneficiary in your will, trust, life insurance, or retirement plan is a wonderful way to provide an enduring legacy. Through a bequest you are able to designate either a specific dollar amount or a percentage of your estate after other disbursements.

Gifts-In-Kind

Nursing facility residents have restricted funds, yet many needs. If you would like to donate individual items for a resident, contact our office and our ombudsmen will be sure the items are given to residents with the greatest need. Residents often request clothing, toiletries, stationery, postage stamps, games, etc.

Please call the NHOA office at (859)-277-9215 with any questions or concerns.

All personal information you provide is kept confidential. NHOA does not share or sell database information for any reason.

A Note from a Member of the Board of Directors

When a family member or a close friend enters a nursing home for an extended stay, everyone involved enters a new phase of life – one for which you may not be prepared. The specialized language of institutional healthcare has to be interpreted. Important decisions have to be made. An ombudsman can offer advocacy, solace, and/or friendship for the resident and you.

As the daughter of a long-term care resident, I came to know that I could count on the ombudsman to help me. Imagine how invaluable this service is for a nursing home resident who has no family, no friends, and no visitors.

When my mother passed away, I wanted to make sure that other residents and families could take advantage of ombudsman services. We made contributions to the Nursing Home Ombudsman Agency of the Bluegrass (NHOA), and I agreed to serve as a volunteer on the Board of Directors. Unless those of us who need and use this service are willing to support it, it might not be there for us and for our friends.

Your participation in our volunteer visitor program can extend our outreach to residents. Donations and bequests to NHOA can be a way for you to continue a much-needed service and extend our outreach to residents.

Stacia Yadon Kaufmann