Improving the quality of care for residents of long-term care facilities

From *Admission* to *Care*

Everything you need to know
about residential long-term care in Kentucky

nhoa

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Nursing Home Ombudsman Agency
of the Bluegrass

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This booklet provides general information and is not a source of legal advice. For specific questions about legal matters, consult your attorney or legal services provider. Don't delay seeking legal advice, disregard legal advice, or begin or discontinue any legal action because of information provided in this document.

A Note from the District Ombudsman

Your 80-year-old mother needs more care than you're able to provide at home, and you're thinking about moving her to a long-term care facility. What do you need to know to make the best decision for her?

We answer that question and others in this booklet. In fact, we help thousands of individuals and families every year with nursing facility placement, care planning, and questions about legal rights, abuse, Medicare, Medicaid, and other concerns. Residents and families tell us the first few weeks after moving into a nursing facility can be challenging, partly because of the unknown. They don't know what to expect. They aren't prepared to deal with the issues involved in moving from home to a long-term care facility. The transition can be difficult for everyone.

The Nursing Home Ombudsman Agency of the Bluegrass and our team of trained, certified ombudsmen are here to help. Ombudsmen typically visit new residents within two weeks of move-in to introduce themselves and tell residents about their special legal rights. They continue to make regular, unannounced visits to monitor residents' health and well-being and to ensure they're being treated with respect and dignity. If you haven't met the ombudsman for your facility, please call our office at 859-277-9215, and we will arrange a visit.

We want to stay in touch with you. For updates and information, visit www.ombuddy.org. To receive our newsletter and information about more urgent matters, call or email us at nhoa@ombuddy.org, and we will add you to our mailing list. For questions about other matters, please call us at the number listed above.

Alice Rearick
Bluegrass District Ombudsman

OUR VISION
The Nursing Home Ombudsman Agency of the Bluegrass envisions a world where aging and disability come with value, ease, dignity, and hope.

OUR MISSION
NHOA's mission is to demand the highest quality of care for long-term care residents through empowerment, support, education, and advocacy.

OUR GOALS
- Protect the rights of long-term care residents.
- Identify, investigate and resolve residents' concerns.
- Empower residents to make informed choices.
- Work to enact laws protecting older and disabled Kentuckians.
- Visit residents as often as possible.

BY THE NUMBERS
There are more than 6,800 residents living in 113 long-term care facilities in the Bluegrass District.

Of that number,

- 12 percent are under the age of 65
- 50 percent have Alzheimer's disease or another form of dementia
- 60 percent have no visitors, ever, from outside the facility
- 70 percent are impoverished
- 80 percent are women.

NHOA ombudsmen make thousands of visits each year to long- term care facilities. They identify, investigate, and work to resolve hundreds of problems and complaints. The majority of issues center on quality of care resulting in abuse and neglect, injuries, falls, pressure ulcers, and failure to respond to call bells, follow physician orders, and notice changes in a resident's condition.

HISTORY AND MISSION

Founded in 1981 and headquartered in Lexington, Kentucky, NHOA is an independent, non-profit organization that relies on financial support from individuals and organizations to fulfill its mission. NHOA provides certified long-term care ombudsmen to advocate for residents. They do this by establishing relationships with residents and families. Residents know they have an advocate at their side at all times, which makes them feel protected and loved.

NHOA serves everyone who needs assistance, regardless of age, race, ethnicity, religion, gender, sexual orientation, gender identity, national origin, and disability. There's never a charge for NHOA's services, thanks to the regular, loyal support of many individuals and organizations.

NHOA houses the office of the Kentucky State Long-Term Care Ombudsman and the Bluegrass District Long-Term Care program. NHOA's Bluegrass District Program is nationally recognized for its low resident-to-ombudsman ratio. Our ombudsmen are part-time employees who live near the facilities they serve. A model ombudsman program dedicated to implementing innovative, research- based practices, we freely share information and training guides with other ombudsman organizations throughout the United States.

What is an ombudsman?
"Ombudsman" (om-buh dz-muh n) is a Swedish word for advocate. Federal law gives ombudsmen the power to intervene on behalf of residents of long-term care facilities. Ombudsmen are trained to impartially investigate and resolve residents' concerns. They also provide information and make referrals to community resources.

Your ombudsman is not an employee of the nursing facility or government agency. *Your ombudsman works for you, **free of charge**.*

What can I expect from an ombudsman?
Your ombudsman will regularly visit your family member in the nursing facility and provide education about residents' rights. Because their sole focus is improving the quality of care for residents, ombudsmen often are the first to notice changes in health and well being.

Although ombudsmen empower and encourage residents and families to advocate for themselves, they know this isn't always possible. They understand the power imbalance in the resident-caregiver relationship. Therefore, they're always available to step forward for residents.

With the resident's consent, ombudsmen investigate complaints. They share the results of the investigation with the resident and/or the resident's legal representative and explain options for resolving concerns. They also follow up with residents to make sure problems are resolved and solutions remain in effect.

Ombudsmen also guide families through the complex nursing facility system. They know where to find information about services, rights, benefits, and regulations. Ombudsmen can connect residents and families to Family Councils and Resident Councils in their facilities. They also are available to accompany residents and families to care plan and other meetings with facility staff.

Ombudsmen can assist in reporting abuse, neglect, and exploitation to state officials. In Kentucky, anyone who suspects abuse has occurred is required to report it to Adult Protective Services (APS) by calling 1-800-752-6200; this can be done anonymously.

The Office of Inspector General's Division of Health Care (OIG) is a state agency that inspects facilities. OIG investigates to determine if facilities have violated state and federal regulations. Consumers may file reports directly by calling OIG at 1-502-564-7963. NHOA also may make reports on behalf of residents.

Is there an ombudsman in my area?
The Nursing Home Ombudsman Agency of the Bluegrass serves 17 counties of central Kentucky that comprise the Bluegrass Area Development District; it is one of Kentucky's 15 state-designated "area development districts (ADDs)."

All 15 area development districts have an ombudsman program. Please call or visit www.ombuddy.org for contact information for ombudsmen in other districts of the Commonwealth.

Getting into a Nursing Facility

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

The first thing to do, if feasible, is discuss the need for placement with the friend or family member who needs help. It's unethical to force an individual into a nursing facility or other long-term care facility against his/her will, as long as he/she is considered legally competent and has decision-making capacity.

Once the issue of consent has been addressed, placement choices depend on several factors, including:

- **payment source, initially and long term**
- **level of care resident needs**

Families, chosen families, and loved ones may be tempted to make placement decisions that go *against the wishes of their loved one*. Sometimes, families think they must coerce placement or conceal the true nature of placement. Being open and honest with the prospective resident is critical. In time, Uncle Charlie may forgive loved ones for moving him to a nursing facility against his wishes. However, it will be more difficult for him to forgive anyone who tricked, manipulated, or lied to him. To avoid this, families should discuss health, financial, and work situations in advance to determine the best and most realistic options.

In some cases, it may be wise to talk with an ombudsman, social worker, or attorney to determine who has ultimate responsibility for decisions when the prospective resident is a legally competent adult with decisional capacity, a legally competent adult who lacks decisional capacity, or an adult who has given permission for someone else to make decisions on his/her behalf.

Prospective residents, even those with dementia, should be involved in all discussions and decisions. Failure to include them can be very upsetting and make the adjustment to placement much more difficult. Individuals with dementia may hear only portions of the conversation and misinterpret them, with unpredictable reactions.

Some individuals choose to live in a nursing home. For people who have been socially isolated and those in fragile health, it can be a positive experience. These residents value the congregate setting and find it reassuring to have nursing assistance available.

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.

Are there options other than moving into a licensed long-term care facility?
Yes. Many individuals choose to live at home with a combination of in-home services.

The Bluegrass Area Agency on Aging and Independent Living offers information about senior centers, adult day care, family caregiver support programs, and homecare services.

The Bluegrass Area Agency on Aging and Independent Living may be reached at (859)-269-8021 or toll free at 1-866-229-0018. Visit www.bgadd.org to obtain a copy of "Pathways", a comprehensive guide for older adults and their caregivers.

How do I find long-term care placement for someone who's in the hospital?
For hospital patients, the ultimate responsibility for finding placement lies with the hospital or discharge planner. NHOA recommends working with the discharge planner in the search for a facility and visiting facilities being considered prior to placement. In some parts of Kentucky, nursing facility beds are scarce, and there's little choice for consumers. From the nursing facility's point of view, individuals who have Medicare reimbursement and are being placed by hospitals are the most desirable prospects.

Placement from a hospital is generally easier than placement from home setting because:
• some long-term care policies pay benefits only when the prospective resident is going to the nursing home immediately following hospitalization
• the nursing facility may be able to secure Medicare reimbursement for up to 100 days, depending on the resident's diagnosis and progress
• the hospital sends required admission documents, such as recent diagnoses and assessments, to the nursing home.

What is the process for moving from a home to a nursing facility?
Prospective residents should provide facilities being considered with copies of their medical history, results of a recent physical, a list of medications, and proof of being seen by a physician within 30 days of admission.

As you attempt to gain admission for your loved one, contact the facility regularly and politely to stay in the forefront of the mind of the person in charge of admission. Don't rely on a facility's "waiting list," often a tool to pacify families of Medicaid-eligible residents. In Kentucky, nursing facilities have the luxury of picking and choosing among applicants. They tend to choose applicants who best serve *their* needs.

BUYER BEWARE

If you give the responsibility of finding a facility to the hospital, you may have little say in the choice.

Hospitals have strong financial incentives to discharge patients once they no longer need hospital care.

Sometimes families focus on finding special care units for residents with memory disorders or behaviors that may be difficult for caregivers to manage. Federal and state regulations require facilities to have individualized care plans for each resident. Facilities are responsible for meeting the resident's needs, regardless of where the resident lives within the facility. Therefore, in most cases, residents and families ***shouldn't have to pay a surcharge to receive care that's required by state and federal law.***

How does a resident move from one nursing facility to another?
Responsibility for placement at a different facility lies with the person or entity initiating the transfer.

Resident-Initiated Move
Responsibility for securing new placement rests with the resident if he/she initiates the move. However, the social services department of the current facility is required to provide assistance. In an Assisted Living Community, Personal Care Home, or Family Care Home, the administrator may give assistance but is not required to do so.

Facility-Initiated Move
When the facility initiates a transfer—regardless of the reason—it's responsible for securing new placement for the resident. The facility also must adhere to laws regarding proper transfer and discharge.

A resident who has been asked to move but doesn't want to move should contact his or her ombudsman.

Selecting a Facility

LOCATION

Is the facility close enough to visit on a regular basis?

Is the facility easy to reach during bad weather or an emergency?

PERSONAL PREFERENCES

Will my loved one be comfortable with the room layout and décor?

Are residents dressed appropriately and well groomed?

Do residents appear to be comfortable and content?

Are there other residents with similar interests or backgrounds?

HELPFUL SERVICES

What types of therapy does the facility provide?

Is the Ombudsman's contact information prominently displayed in the facility?

Are there transportation services?

Are there religious/spiritual services?

Are residents' rights posted in the facility?

Is there a barber or beautician?

ENGAGING ACTIVITIES

Are planned activities posted?

Does the facility offer activities that my loved one will enjoy?

Is it okay to visit and participate in activities with residents?

CARING STAFF

Do I see staff interacting with residents in a friendly and warm manner?

Is staff available throughout the facility?

Do staff appropriately supervise residents?

MEAL TIME

Is the food appealing to my loved one?

Are residents eating and enjoying their meals?

Is staff available to help residents who need assistance eating?

APPROPRIATE SURROUNDINGS

Are the surroundings clean and neat?

Are there offensive odors in the air?

Is it noisy because of loud voices, loud public address systems, or TVs?

Do I notice unanswered call lights?

Do common areas look inviting and comfortable?

Is there adequate space to meet residents' needs?

Are residents' rooms home-like and personalized?

ASK OTHER FAMILIES

Is there an active Family Council at this facility?

What do other families think of the care here?

STATE INSPECTIONS

Are the last three inspections available for your review?

Visit www.medicare.gov/nursinghomecompare for information about nursing homes in your area. Contact NHOA for a list of nursing facilities in the Bluegrass District.

How Will I Pay for Long-Term Care?

Private Pay
Nursing facility residents who don't use Medicare benefits and aren't eligible for Medicaid to pay for their care are considered "private pay." Private-pay residents may use savings, investments, proceeds from the sale of a home, long-term care benefits, or other income to pay the bill.

In this case, the family or prospective resident should carefully consider the following:

When the money runs out, will I medically qualify for nursing home placement? A private-pay resident who runs out of money before becoming ill enough to qualify for Medicaid may not have the option of remaining at the facility.

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

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

There are no limits to what the nursing facility can charge private-pay residents. Therefore, it's important to request an itemized list of services and costs.

Families of private-pay residents should request a Medicaid-certified bed if they think their loved one will qualify for Medicaid coverage in the future. In some facilities, all beds are certified for Medicaid. Individuals and families with few resources should avoid facilities with few or no certified beds. It's illegal for the facility to directly inquire how much money an applicant has. However, facility staff are permitted to ask when the resident will become eligible for Medicaid.

Families may want to consider other community services or long-term care options until nursing facility placement becomes a medical necessity.

Medicaid
Medicaid is a state- and federally-administered insurance plan which can help individuals who require long-term care receive nursing care in a Medicaid-certified bed. Medicaid pays for skilled services and lower intensity intermediate care. Medicaid also covers Medicare deductibles and up to 14 bed-hold days per calendar year. Residents must meet Medicaid's patient need criteria to qualify.

Generally, Medicaid becomes the primary payor when a resident exhausts the skilled nursing facility benefit to which they are entitled under the terms of their Medicare coverage.

If the prospective resident needs nursing care and will use Medicaid benefits immediately to pay for it, it may be difficult finding placement. That's because the resident's payment source is pending. Families should visit potential facilities, explain their need, and be open about finances. Also, they should cooperate fully in securing medical information required for admission and financial information for Medicaid applications. It's illegal for a facility to discriminate against applicants based on their source of payment, diagnoses, or disability.

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

Many residents and families are shocked to learn that most or all of a resident's income must be applied to the nursing home bill to pay for medical care, meals, boarding, and supplies. Medicaid determines the portion of the monthly nursing home bill, or the "patient liability," the resident is responsible to pay. For many single residents, the "patient liability" takes all of their monthly income except $40, which they may use for personal needs.

Residents who choose to pay credit card bills, loans etc. instead of paying their monthly "patient liability" to the nursing home risk being discharged/evicted. Furthermore, it's against the law for families, legal representatives, or anyone to use a resident's money for themselves instead of the resident. Financial exploitation of a vulnerable adult is a serious crime.

Who is eligible for Medicaid nursing facility services?
Individuals who meet the following requirements may be eligible:

- reside in a facility that participates in the Kentucky Medicaid Program and 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 ages 65–up, blind, disabled, or Medicaid-eligible.

BE AWARE
It's important to be organized for your Medicaid appointments. Make copies of all requested documents and get a receipt for every piece of documentation you submit in support of your application.The resident may have to liquidate and spend down resources. For example, you may have to sell your second car and prove you used the proceeds to pay Medicaid-allowable expenses.

What resources will be considered?
The resources of an individual residing in a nursing facility must be within Medicaid guidelines. For married applicants, resources of the spouse also are considered. Medicaid may deny a resident's application if he/she has too much value in financial resources.

"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, bonds, certificates of deposits, automobiles, land, buildings, burial reserves, and life insurance policies.

Certain types of resources are excluded. They may include, but are not limited to, a home and adjoining land, household goods, personal effects, funeral expenses, 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). and are not considered in the Medicaid eligibility determination.

A resident's home equity interest up to $713,000 is an exempted asset for the first six months of his/her stay. After six months, Medicaid may request that the resident's home be put on the market for sale. The resident has the option to submit a statement of intent to return to that home, with an estimated date, which would extend the exemption for another six months. Proceeds from the sale of a home are considered an "available asset" and disqualify the resident from receiving further Medicaid benefits until the money is spent on "allowable" expenses. Homestead property with an equity value less than $688,000 may be exempted when a community spouse (the spouse living at home) or certain other family members live there. Talk with a Medicaid representative to determine whether you qualify.

Marital Status	Living Arrangement	Resource Limit
Single	Resident	$2,000
Married couple	Both residents	$2,000 each
Married couple	One member of the couple is a nursing facility resident; the other remains at home	**50%** of joint resources but no less than $30,828 or more than $154,140

Financial Resources and the Community Spouse
At the request of either spouse or interested party representing the couple, the Department for Community- Based Services (DCBS) may perform an assessment of the combined countable resources of the spouse living in the nursing facility and the "community" spouse (the one living at home). The resource assessment, which may be completed without applying for Medicaid, involves documenting and verifying countable resources owned by the couple as of the date of the resident's most recent admission to the nursing facility. Both members of the couple receive a copy of the assessment.

A single resident is allowed to retain **$2,000** in non-excluded financial resources. A community spouse may keep **50% of couple's joint resources**, but no less than **$30,828** and no more than **$154,140**. The resident and spouse have six months from the application date to ensure the property is properly owned and therefore qualifies for the resource exclusion. DCBS staff can offer guidance in this matter. Any money a couple has over these limits will be used to pay the nursing facility bill and may 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 be penalized if the applicant gives the asset 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 resources were transferred.

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

- a spouse
- a child who is under age 21 or a disabled child of any age
- a child who has lived with the resident and provided care for the resident for at least two years, thereby avoiding institutionalization of the prospective resident
- a sibling who has equity interest in the home and lived with the resident prior for one year prior to institutionalization for one year, and provided care for the resident.

The living arrangement must be documented with statements by two collateral sources such as a neighbor, physician, minister etc. Family members aren't considered 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 **$2,829** per month, the nursing facility resident is income-eligible.

Those with income exceeding **$2,829** can still qualify for Medicaid nursing facility coverage by placing all of their excess income into a Qualifying Income Trust (QIT). In most cases, income in excess of **$2,829** will be placed in the trust and can be used to pay for the resident's care, according to the terms of the trust. Legal assistance is required to draft the trust.

Patient Liability
The portion of the nursing home bill a resident receiving Medicaid must pay is known 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 to be paid to the nursing facility.

How do I apply?
The Department for Community-Based Services (DCBS) processes Medicaid applications for the Kentucky Department of Medicaid. An application for Medicaid may be filed at the local Department for Community-Based Services Office.

To begin the application process, call 1-855-306-8959 to request an appointment. You may also call this number to ask questions, express concerns, and to check the status of your case.

Prepare for your appointment by gathering the following documents:

- gross income, earned and unearned
- certificates of deposit statement
- life insurance policies with most recent statement showing cash value
- prepaid burial arrangements or irrevocable burial trusts
- deeds to real estate
- health insurance
- medical bills
- Social Security number
- bank statements
- proof of identity with photo
- birth certificate or other proof of citizenship
- IRA and annuity statements
- broker statement of investment portfolio

This list is not all-inclusive; other documents may be required to complete an application for Medicaid eligibility. Resource and income limits usually change in January to adjust for inflation.

Medicaid eligibility requirements are updated each year. Check Medicaid's website for the most accurate information.

What do I do if my application is denied?
Residents have the right to appeal Medicaid's decision to deny long-term care coverage. Appeals must be filed within 30 days of the date on the denial letter. Legal assistance may be needed to file the appeal. Legal Aid of the Bluegrass (1-800-888-8189) is one source of assistance for residents with Medicaid denials.

Medicaid Estate Recovery
The state may try to recover costs for medical care that Medicaid has paid during an individual's lifetime. This is called Medicaid Estate Recovery. Anyone who receives services in a nursing facility or 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. Contact an attorney with questions.

Changes to these and other regulations can occur at any time. Consumers should consult the Department for Medicaid Services website for the most current information. The web address is https://chfs.ky.gov/agencies/dms/Pages/default.aspx.

CONTACT MEDICAID
For more information, visit https://www.chfs.ky.gov/agencies/dms/Pages/default.aspx or call 1-855-306-8959.

CONTACT MEDICARE
For more information about your Medicare plan, visit www.MyMedicare.gov or call 1-800-MEDICARE (1-800-633-4227).

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 and for certain reasons**.

When a facility staff member says, "She's skilled," it can mean one or all of the following:
• Medicare is paying the bill
• resident has complex care needs
• individual lives in the "skilled care" part of the facility.

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.

"Skilled care" refers to services provided by medical professionals such as registered nurses, physical therapists, dentists, occupational therapists, audiologists, etc. To qualify for skilled care, an individual must require professional services on a daily basis. In addition, services must be those that can only be provided on an in-patient basis.

"Benefit period" is the way Medicare measures 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 expenses except for the Part A deductible, which is currently $1,632.

If there is an extended stay (past 60 days), days 61-90 have a co-insurance of $408 a day. The resident is responsible for this amount.

A stay longer than 90 days is eligible for "lifetime reserve" days. A beneficiary has 60 lifetime reserve days for stays longer than 90 days. These can be used for one day or used all at once. The resident is responsible for the co-payment of $816 per day.

Sixty days must pass between a discharge and readmission for the resident to be in a new benefit period. The hospital can't bill for 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 of $200 a day (subject to change).

The resident may use Medicaid, Medigap insurance, or cash for the co-payment. A day is counted when the resident is present for the midnight census.

If readmission occurs within 30 days of discharge from the SNF, the SNF benefit period picks up at day of discharge. If readmission occurs after 30 days, a three-day hospital stay is required before renewal of SNF benefits.

The qualifying three-day hospital stay expires if long-term care is not used within 30 days of hospitalization.

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

Does Medicare pay for custodial care?
Medicare does not pay for assistance with activities of daily living, also known as "custodial care." Examples include getting in and out of bed, eating, bathing, dressing, and toileting. However, Medicare may cover treatments that must be administered by someone with professional skills or training.

What if Medicare won't pay for a therapy my loved one needs?
Residents have the right to ask the facility to submit a "demand bill" to Medicare when Medicare denies benefits. An outside, impartial medical professional will review the denial of benefits. Medicare has three days to uphold or reverse the facility's decision. The resident isn't obligated to pay for those three days, regardless of Medicare's decision. If the decision goes against the resident, the resident may appeal. If the resident loses the appeal, he/ she must pay the bill.

It's important to note that if Medicare stops paying for a particular therapy, it doesn't necessarily mean that the resident no longer needs the therapy. It may mean that the individual has met the maximum allowable benefit for therapy. The facility must notify the resident and family of the cost for therapy in advance, should they decide to continue with it.

Nursing facilities frequently tell residents they are being "discharged" from Medicare because they aren't improving or have "plateaued". However, a resident may still qualify for Medicare coverage as they plateau. The *Jimmo v. Sebelius* settlement in 2013 affirmed Medicare coverage of professional nursing and therapy services needed to maintain a resident's function or prevent or to slow the resident's deterioration or decline. The settlement applies both to traditional Medicare (Parts A and B) and to Medicare Advantage plans (managed care). It firmly rejects as inconsistent with the Medicare law nursing erroneous statements that Medicare won't pay for additional days of care when the resident has "plateaued" or "is not improving."

Residents and families often misinterpret a discharge from Medicare to mean they're being discharged from the facility. However, residents may appeal the Medicare discharge or use another payor source to remain in the nursing home.

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 do I appeal Medicare's 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, read the **Medicare Summary Notice (MSN)** which lists the item or service you will appeal. The MSN is the quarterly statement that lists services billed to Medicare and whether Medicare paid for them. Then do the following:

- Circle the item(s) on the MSN you disagree with and write the reason you disagree on the MSN document.
- Include your telephone number, Medicare number, and sign the document. Keep a copy for
- your records.

• Include any additional information that might be helpful on the MSN and send to the Medicare contractor's address listed on the MSN.

You must file the appeal within 120 days of the date you receive the MSN. Read the MSN carefully and follow instructions if you plan to file an appeal.

Contact your State Health Insurance Assistance Program (SHIP) at 1-877-293-7447 or visit https://www.chfs.ky.gov/agencies/dail/Pages/ship.aspx if you need help filing an appeal.

Hospital Discharge

Role of the Hospital Discharge Planner
When a patient is hospitalized, it can be a very difficult time for the patient and family. Hospitals have discharge planners who assist families when a patient is being discharged from a hospital. Ther are there to support the family and help the elder throughout the hospital stay. Discharge planners are usually social workers, but sometimes are nurses or other health care professionals. The discharge planner's role in helping the patient will vary depending on the patient's needs and family's request for services, but the primary role of the discharge planner is to help the patient make decisions, provide support, and coordinate needed services after the hospital stay.

How can Discharge Planners Help the Family?
Discharge planners can help families in many ways when a patient is hospitalized. Before the patient is discharged from the hospital, a discharge planner will assess their needs, discuss these needs with the family, and develop a plan of action. An assessment of evaluation is completed to help the discharge planner determine what level of care is needed, so the patient can maintain the maximum level of independence after the hospital stay.

Discharge planners are also advocates. If concerns are expressed during the patient's hospital stay, the discharge planner will help resolve matters. They will also help the family with payment issues. Sometimes Medicare will discontinue payment and the family will receive a "Notice of Con Coverage." If this happens, the family has the right to appeal this decision to a Peer Review Organization. The discharge planner will usually help the family understand the forms and assist with the appeal process.

The most important and primary role of the discharge planner is coordinating services. After an assessment is completed, the patient's needs are identified and discussed with the family, the discharge planner will coordinate any services that are needed.

Options After Discharge
Sometimes patients are discharged from a hospital stay and cannot function at home without some kind of assistance. Home health care may be needed and ordered by the physician. Medicare will cover home health care is the doctor orders the patient needs "skilled care" at home to rehabilitate. Discharge planners can also coordinate other needed services that Medicare will not cover such as meals on wheels (hot, nutritious meal delivered to the home), homemaker services (light housekeeping, laundry, and meal preparation), arrange for transportation, or help find a private duty sitter or companion. Many services exist in the community to help patients so they can remain at home. Discharge planners will explain to the family the options available and refer the family to the appropriate agency that can provide the needed services.

Sometimes the patient is unable to return home and needs to be temporarily in a nursing home, or possibly long-term if unable to rehabilitate due to a serious injury or condition. Nursing homes can provide twenty-four hour nursing care and intensive therapy that cannot be provided in someone's home. Being discharged to a nursing home may be the best options if the patient needs intensive rehabilitation. It is important to know that it is easier to be admitted to a nursing home coming from a hospital stay than coming from home, so consider all the options available before making a decision to be discharged home if intensive rehabilitation is needed. Discharge planners will help the family with this decision and locate an appropriate nursing home.

What Can the Family Do to Help?
The family should write down a lost of concerns and questions, so it can be addressed when meeting with the discharge planner. Also, it is important that the family be assertive while the patient is hospitalized. If a discharge planner has not initiated contact with the family, go ahead and locate this person. Sometimes patients are discharged without the assistance of a discharge planner. Remember, every hospital has a discharge planner, so make sure they are providing the services that are needed to help the family through this process.

What to Expect on Moving Day

Will I have to sign a contract?
Yes. An admission contract is a legally binding document that describes the relationship between the nursing facility and the resident, services the facility provides, the rights and responsibilities of the resident, and the amounts charged for care. The facility is required to use clear language, both written and oral, to inform residents of services they will receive. A copy of the signed contract services must be kept in the resident's file.

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.

This is a legally binding document; therefore, it is crucial to read carefully and understand it before signing. The facility wrote the contract and took care to ensure it protects the facility's interests first. Admission contracts may contain misleading and unenforceable clauses. Some attempt to convince residents that they have fewer rights than they actually have, and that the facility has fewer responsibilities than it actually does.

Obtain a copy of the signed contract before leaving the building. Information regarding residents' rights and contact information for the Ombudsman working in that facility may be included in the packet of information the facility gives new residents and families.

Will I have to pay a deposit?
Nursing facilities often require an individual seeking placement to make a cash deposit as a condition of admission if the bill won't be covered by Medicare or Medicaid.

Facilities *may not*
• require a deposit for admission of an individual covered by Medicare or Medicaid.
• require pre-payment as a condition of admission for care covered by either Medicare or Medicaid.
• require a third-party guarantor for a Medicaid-eligible applicant as a condition of admission.

Facilities *may*
• request that the Medicare beneficiary (resident) pay co-insurance amounts and other charges for which he/she is responsible. These charges should be paid as they become due but not in advance.
• collect a refundable security deposit, if the resident has applied for Medicaid but hasn't received a letter regarding determination of eligibility. If the resident is later determined to be eligible, the facility must refund the deposit prior to billing Medicaid.

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

What emotional reactions can we expect from our loved one?
Moving to a nursing facility is a life-changing event. Residents may feel angry, abandoned, and depressed. Families may feel regret, guilt, doubt, and frustration. Encourage family members to openly discuss their feelings.

The Ombudsman and facility staff can help by giving the resident time to adjust to his or her new surroundings. Spending extra time with him/her in the beginning can relieve feelings of abandonment. To further smooth the transition, include the resident in decisions about care, visitors, outings, and room furnishings.

May we personalize the room?
Most residents have a roommate, which limits space for personal belongings. Nonetheless, it's important to make the room feel home-like. This can be accomplished by bringing a small bookcase, side table, comfortable bedside chair, photographs, clock radio, pillows, and toiletries.

How do I protect personal belongings?
Label everything with the resident's first and last name, even if a family member or friend is doing the laundry. Things often get placed in the facility's laundry by mistake.

There should be a personal inventory list for every resident at the nurses' station. This list includes hearing aids, glasses, televisions, phones, and all other belongings. When you take your loved one something new, label it and add it to the list. Likewise, delete items from the list when you remove them from the permanent facility.

Regardless of measures taken to prevent theft, it happens. Keep expensive or sentimental belongings, such as jewelry, in a safe place outside the facility or in a lockable bedside drawer.

Many families take photos of the resident with their personal belongings so there is a record in case of loss. Photos can depict the resident wearing dentures, hearing aids, glasses, sitting in his or her own wheelchair, or covered by a favorite quilt. Obtain the resident's permission before taking photos.

Hearing aids have a serial number that can be recorded in the resident's chart. Some styles, such as those worn behind the ear, can be fitted with a chain and clip that attaches to the wearer's shirt. Ask the dentist about engraving your loved one's dentures. It's easier to get dentures engraved at the time they're made; however, they can be engraved later.

Nursing Facility Staff Titles and Responsibilities

• **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 meeting the nutritional needs of residents. Some facilities contract with dietitians for 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 also is a registered nurse (RN).
• **Head of Housekeeping** Manages the housekeeping department, responsible for cleanliness of the facility and laundry services.
• **Head of Maintenance** Oversees maintenance of the facility.
• **Licensed Practical Nurse (LPN)** Works under the direction of the DON; supervises state-registered nurse aide, and provides direct care to residents.
• **Medical Director** Physician responsible for medical care of all residents. Required by law to visit the resident once in a three-month period. Some send physicians' assistants and/or nurse practitioners in their place.
• **Occupational Therapist** fits residents with assistive devices such as wheelchairs, positioning cushions, walkers, etc.
• **Physical Therapist** provides help with movement through a program of exercises.
• **Registered Nurse (RN)** Provide and coordinate patient care, educate patients and the public about various health conditions, and provide advice and emotional support to patients and their families.
• **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, obtaining medical devices such as hearing aids, glasses, dentures, and wheelchairs. If a facility has more than 120 beds, it must have 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, including bathing, feeding, and dressing, under the supervision of the nursing staff.
• **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 Ombudsman is a good source of information about the workings of the facility. He or she can identify the change makers in your facility so you don't waste time and energy addressing complaints to the wrong person.

Resident Care Requirements in Nursing Facilities

What's a care plan?
A care plan is a document that describes how facility staff will meet a resident's individual needs and preferences. It's developed at the initial care planning conference, reviewed every three months, and revised as the resident's needs change.

At a care planning conference, staff, residents, family, and/or the resident's chosen representative may talk and ask questions about aspects of life in the facility. Medication, personal care, staff, activities, exercise, therapies, food, and use of restraints are a few topics that may come up.

Residents and their families or representatives should share information that will help staff provide individualized care. This may include reviewing medical and care records prior to the care plan meeting.

The Ombudsman is available to assist in preparing for the meeting and to attend, at the resident's request.

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. Federal law applies only to Medicare and Medicaid-approved nursing facilities. Kentucky law applies to all Kentucky nursing facilities. Most Kentucky nursing facilities are Medicare- or Medicaid-approved.

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.**

Federal law contains four key standards for nursing facility care:
• The nursing facility must provide services to help each resident attain or maintain the highest practicable physical, mental, and psycho-social well-being.
• A resident's ability to bathe, dress, groom, transfer, walk, toilet, eat, and communicate must not decline unless it is medically unavoidable.
• 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.
• Residents have the right to make choices about their care.

In addition, Kentucky and federal laws set minimum requirements for nursing homes in providing daily care. They include, but aren't limited to, the following:

• **General Hygiene** The nursing home should provide help with general personal hygiene (skin, oral, and hair) for those who need it. Residents should 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 sit or lie in one position for long periods of time often develop "pressure sores," also known as bed sores. Pressure on the skin from prolonged sitting or lying without changing position prevents blood vessels from carrying nutrients to the affected area. Skin breakdowns can lead to large sores, infections, and severe pain if left untreated. Poor nutrition and certain conditions also may result in pressure ulcers. Residents confined to a bed or chair should be checked and repositioned (turned) every two hours or more often, if the resident is uncomfortable. The facility should use supportive devices, special mattresses, pads, and pillows to maintain normal body posture and relieve pressure. Facility staff should provide daily help with walking and exercise to maintain or improve circulation, strength, and use of the body.

Family's role in care plan
• 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.

• **Dressing** Residents should be dressed in their own clean, comfortable clothing each day. Residents who walk should wear appropriate footwear; non-ambulatory residents should wear 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. Those who are incontinent (no control of bowels or bladder) and become wet or soiled should be cleaned and changed quickly. Incontinent residents should receive care to restore as much normal bowel and bladder function as possible.

• **Eating** Facility staff should assist residents as needed during meals. This may include opening packages, securing special utensils, and helping residents eat. 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 residents receives sufficient fluids to maintain good health and prevent dehydration. Fresh water and drinking cups must be on each bedside table.

• **Vital Signs.** Facility staff must weigh and check blood pressure, temperature, respiration rate, and pulse of residents upon admission. This should be repeated monthly, at minimum, and more often if ordered by a physician.

• **Special Needs** Facility staff must arrange for special services such as dental, podiatry, vision, and hearing; physical, speech, and occupational therapy; mental health evaluation and treatment, and respiratory care.

This guide summarizes some, but not all, of the daily care requirements Kentucky nursing facilities must meet. Please contact our office at (859) 277-9215 with questions about these and other requirements.

Relationships between Residents, Family, "Chosen Family," and Friends

Guardian When the court determines an individual is incompetent, the individual loses all rights as an adult, and a guardian is named. The guardian oversee all of the individual's affairs.

For information about guardianship, visit http://www.kypa.net/home.html. In Lexington, call Fayette District Court at 859-246-2240.

Limited Guardianship Limited guardianship is determined through the same procedure as guardianship and is used when a person is unable to make decisions about his or her personal care. The court grants personal care rights only to the Limited Guardian.

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 An individual may appoint another individual Power of attorney (POA). Powers of attorney are generally used to handle specific tasks such as paying bills, depositing checks, etc. Power of attorney ceases when an individual becomes mentally incapacitated, unless the POA also is a durable POA.

The person who has power of attorney is known as the Attorney in Fact. Never give anyone who isn't completely trustworthy power of attorney.

Durable POA Durable POA differs from regular POA. Durable POA specifically states that authority continues, even in cases of disability.

Next of Kin Next of kin refers to the resident's closest relative(s). No legal obligation is implied.

For information about appointing a power of attorney, call Legal Aid of the Bluegrass at 859-431-8200.

Interested Family Member The nursing facility may designate a family member or close friend as an Interested Family Member (IFM). This is not a legal designation; the Interested Family Member and the resident may terminate the relationship at any time.

The nursing facility may ask the Interested Family Member to make certain decisions regarding the resident's care and to do things for the resident, such as buy clothing.

Contact the Social Security Administration

If you have questions about social security benefits, call 1-800-772-1213 or visit www.ssa.gov.

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

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 is the representative payee. For example, a check for James Smith is paid to Lucy Jones, and Lucy pays the facility. The benefit check also may be sent 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.

The Right to Care Without Discrimination

Do civil rights laws apply to nursing facilities?
Almost all Kentucky nursing facilities participate in the federal Medicare or Medicaid programs. To do so, they must agree 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 should I do if discrimination occurs?
You may file a complaint online or by phone at the address and phone number at the bottom of the page if you believe your loved one has experienced discrimination based on race, color, national origin, age, sex, handicap, or religion by a Medicare- or Medicaid-approved nursing facility. The Office for Civil Rights, a division of the United States Department of Health and Human Services (DHHS), makes sure organizations receiving federal funds comply with civil rights laws.

If the Office for Civil Rights determines a resident is the subject of discrimination, it will work with the nursing facility to correct the discriminatory action. For example, if the facility improperly denied admission to an individual, it may be asked to grant admission to the individual and announce to the community that it will not discriminate against future applicants. The civil rights office also may suspend or terminate federal funding if the facility doesn't take corrective action.

Written complaints must be signed and contain the following information:
• name, address, and telephone number of the person being discriminated against,
• name and address of the facility you believe discriminated against you or your loved one,
• how, why, and when you believe the discrimination took place, and
• any other relevant information.

The civil rights office will send a "discrimination complaint form" to those who prefer to complete a form rather than write a letter.

Send complaints or request a complaint form from:
Department of Health and Human Services
Regional Manager for Civil Rights
Atlanta Federal Center
61 Forsyth Street SW, Suite 16T70
Atlanta, GA 30303-8909
ocrmail@hhs.gov
https://www.hhs.gov/ocr/about-us/contact-us/index.html
1-800-368-1019
1-800-537-7697 TDD

Restraints

What are physical restraints?
Physical restraints are anything used to restrict, restrain, or prevent movement of a person. Examples include belts, vest restraints, cuffs, and sometimes special chairs or bedside rails.

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 may be used to prevent a person from getting out of bed or 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. A nursing home may use chemical restraints when they perceive a resident as having a "behavior problem." Chemical restraints are often antipsychotic or psychotropic medications, which can be dangerous when prescribed to elderly residents.

Antipsychotic and psychotropic medications are inappropriate if:
• there's no corresponding diagnosis
• there's no documented benefit to the resident
• dose is too high
• dose reductions are not followed.

What are the federal guidelines regarding restraints?
Federal and state laws prohibit nursing facilities from using restraints unless prescribed by a physician for a specific purpose and limited time. Facilities must ensure that restraints don't impede a resident's ability to bathe, dress, walk, toilet, eat, and communicate. These abilities should not decline due to the use of restraints. Residents must be released from physical restraints and repositioned at least every two hours. Physical restraints may only be applied by a qualified professional.

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

Restraints must never be used as a

- permanent means of control;
- form of punishment;
- convenience for the facility staff; or
- substitute for activities or treatment.

Can restraints have a negative impact?
Restraints rarely prevent injuries, and they often create other serious problems.

Physical restraints may cause chronic constipation, incontinence, pressure sores, emotional problems, isolation, and loss of the ability to walk or perform other activities. Residents may also be harmed by improperly applied restraints or while trying to escape a restraint.

Chemical restraints can cause serious medical complications, including over-sedation leading to similar issues caused by physical restraints. Chemical restraints can also cause falls, confusion, and even death.

Chemical restraints such as psychotropic medications also may be prescribed when the facility considers the resident to be a behavior problem. Use and effects of psychotropic drugs must be closely monitored and periodically
reviewed. These drugs are inappropriate if
• The dose is too high.
• Dosage reductions aren't followed.
• There is unjustified chronic use.
• There's no documented benefit to the resident.
• It's the wrong drug for a particular diagnosis or
• If it's an unnecessary duplication.

What are the rights of nursing facility residents regarding the use of restraints?
Residents have the right to refuse treatment, including the use of restraints.

How do I prevent unnecessary use of restraints?
Make sure the nursing facility conducts a careful assessment and considers all options before using restraints. If facility staff know you're well-informed on the subject, they are more likely to respect your wishes. For further assistance, contact the Nursing Home Ombudsman Agency of the Bluegrass at 859-277-9215.

Residents Have the Right

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

How 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 better pay and benefits.
• **Introduce** aides to the residents for 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 of residents, family, staff, representatives and administration.
• Promote an open exchange of ideas, recommendations, and concerns among residents, families, staff, and administration.
• **Build** more private rooms for individual residents and public rooms for private use by residents.
• **Promote** a sense of community within the nursing facility. Organize activities for each wing and each floor. Design activities that promote interaction and intellectual and emotional stimulation.

Five Types of Long-Term Care Facilities

	Skilled Nursing Facility	Nursing Facility	Specialized Personal Care Homes	Family Care Homes	Assisted Living Communities		
					Social Model	Basic Health Model	Dementia Model
Type of Care	Care needs determined by assessment; usually include therapies. "High intensity care" may also be called sub-acute, rehab, or extended care	Care needs determined by assessment; still called *intermediate care* by some; insurance calls this level *custodial care*	Community housing with professional staff. Participates in the mental illness or intellectual disability supplement program. Care needs determined by assessment	Community housing limited to 2-3 residents; managed by an owner-operator	Community housing	Community housing with professional staff. Care needs determined by assessment	Community housing with professional staff trained in dementia care. Care needs determined by assessment
Payor Source	Private funds, Medicaid, Medicare, VA contracts, long-term care insurance	Private funds, Medicaid, VA contracts, long-term care insurance	Private funds, state supplement, VA contracts		Private Funds	Private funds, long-term care insurance, VA contracts	
Residents' Rights per Statute	All state and federal rights	All state rights (and federal if a Medicaid provider)	All states rights	State rights exceptfor transfer and discharge	All states rights		
Living Space	Shared bedrooms and bathrooms; private rooms may be available. Congregate living spaces		Shared bedrooms. Private bedrooms may be available. Congregate living spaces	In a private home; usually shared bedroom; access to all living space in the home	Usually apartment style living with congregate living spaces		
Personal Services	Non-professional support services available, including 24-hour supervision. May receive assistance with shopping, housekeeping, laundry, and transportation. Meals and social activities included.						

	Skilled Nursing Facility	Nursing Facility	Specialized Personal Care Homes	Family Care Homes	Assisted Living		
					Social Model	Basic Health Model	Dementia Model
Health Services	Professional staff required to provide assistance with activities of daily living as determined through assessment. May include bathing, grooming, toileting, and medication management. Care plans are a crucial piece to receiving quality care and should be reviewed every 90 days or when there is a change in condition.		Professional staff required to provide assistance with activities of daily living as determined through assessment. May include bathing, grooming, toileting, and medication management. Resident must be ambulatory or mobile non-ambulatory.	No professional staff required. May be available or provided by contract from home health. Resident must be ambulatory or mobile non-ambulatory.	No professional staff required. Provide assistance with activities of daily living as determined through assessment. May include bathing, grooming, toileting, and self-administration of medication. May contract with outside provider for additional services. Resident must be ambulatory or mobile non-ambulatory.	Professional staff required to provide assistance with activities of daily living as determined through assessment may include bathing, grooming, toileting, and medication management. May contract with outside provider for additional services. Resident must be ambulatory or mobile non-ambulatory	
Regulatory Inspection Schedule and Oversight	Every 7-15 months by the Office of the Inspector General		Every 2 years if previous licensure review does not find serious violations by the Office of the Inspector General	Every 7-15 months by the Office of Inspector General	Every 2 years if previous licensure review does not find any serious violations by the Office of Inspector General		
Adult Protective Services Investigations	The Department of Community Based Services initiates an investigation if abuse, neglect, or exploitation is alleged.						
Ombudsman Services	Yes						
Notes	Even if the unit is in a hospital, it is still a nursing facility		Residents may have Medicaid, but that does not pay for their stay in the specialized personal care home	Residents may have Medicaid, but htat does not pay for their stay in the family care home			

How To Help Residents

The actual cost of providing ombudsman services to the 6,800 residents our Ombudsmen serve annually far exceeds the amount provided by state and federal agencies. We rely on the generosity of many individuals and organizations to bridge the gap. Please join hundreds of other compassionate people in demonstrating your appreciation for long-term care residents' many contributions to society.

WAYS TO GIVE

Checks
Please mail checks payable to NHOA to 3138 Custer Drive, Suite 110, Lexington, KY 40517.

Credit Card
To make a secure gift online using your credit card, visit www.ombuddy.org and click on "Make a Gift Now."

Wini's Wishlist
The majority of long-term care residents are impoverished. Medicaid allows them $40 a month—a little more than a dollar per day—to buy the necessities of daily living such as clothing, shoes, snacks, glasses, stamps, pens, stationery, haircuts, etc.

Please call the NHOA office if you'd like to help with these needs. We will ensure residents with the greatest need receive your donations.

Planned Gifts
A planned gift enables individuals to fulfill their philanthropic goals, often more generously than expected. A planned gift is arranged in advance with the understanding that the beneficiary (charity) will receive a gift following the donor's death. Planned gifts may include life insurance policies, cash, securities, and personal and real property bequeathed in a will. Call NHOA for more information on how you can make a planned gift at 859-277-9215.

Anyone considering making a planned gift should discuss it with an attorney and/or financial advisor.

Time
Become a board member. Email us at nhoa@ombuddy.org or call 859-277-9215 for an application or information.

NHOA will never sell or share your personal information.

Remember a Loved One

Many friends of NHOA pay tribute to loved ones by making gifts in their memory or honor. When making this type of contribution, please tell us:

- honoree's name and address
- donor's name, address, and phone number
- name and address of survivors so we can
- send notification of the gift (amount remains confidential).

Message from the Board of Directors

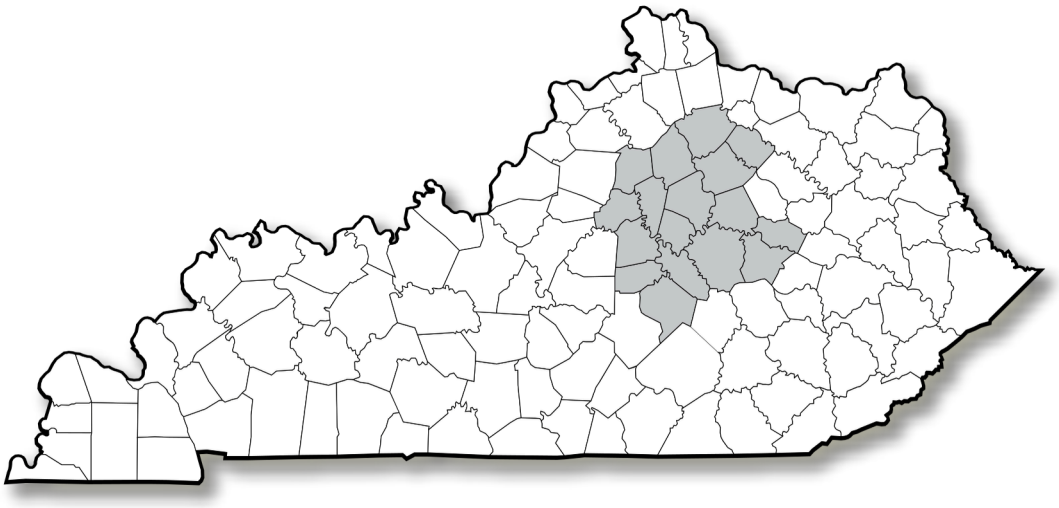
When a family member or a close friend enters a nursing home for an extended stay, everyone involved enters a new phase of life – one for which you may not be prepared.

Someone has to interpret the jargon of institutional healthcare. Important decisions have to be made. A certified NHOA Ombudsman can offer advocacy, solace, and friendship for the resident, family, and friends.

Imagine how invaluable this service is for nursing home residents who have no family, no friends, and no visitors. Sadly, this is the case for 60 percent of the 6,900 residents in Central Kentucky alone.

In addition to providing financial support for the Nursing Home Ombudsman Agency of the Bluegrass, I agreed to serve on the non-profit's all-volunteer board of directors. We who need and use the services of a NHOA Ombudsman must be willing to support it so that it will always be available for friends and relatives.

Please join me in improving the quality of care for residents by making a gift to the Nursing Home Ombudsman Agency. Thank you.



The Nursing Home Ombudsman Agency
improves the quality of care for residents
of long-term care facilities in the following
17 counties of the Bluegrass Area
Development District:
Anderson, Bourbon, Boyle, Clark, Estill,
Fayette, Franklin, Garrard, Harrison,
Jessamine, Lincoln, Madison, Mercer,
Nicholas, Powell, Scott, and Woodford

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