Don't Make Them Leave Their Rights at the Door: A Recommended Model State Statute to Protect the Rights of the Elderly in Nursing Homes

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DON'T MAKE THEM LEAVE THEIR RIGHTS AT THE DOOR: A RECOMMENDED MODEL STATE STATUTE TO PROTECT THE RIGHTS OF THE ELDERLY IN NURSING HOMES.

INTRODUCTION

Historically, the care of the elderly\(^1\) rested in the hands of the family.\(^2\) Longer life expectancies, greater cost of medical care and changes in the structure of the family are responsible for the increased use of nursing homes.\(^3\) Today, 1.5 million Americans live in 15,000 nursing homes at an annual cost of $30 billion — half of which is financed through federal and state programs, primarily Medicare and Medicaid.\(^4\) Pervasive regulation at both the federal and state levels notwithstanding, nightmarish conditions persist in over one third of the nation's certified nursing homes.\(^5\)

Demographers predict an increase in nursing home population to 2.1 million by the year 2000, and by 2040, this will more than double to 4.4 million.\(^6\) The plight of the elderly and the general poor quality of the nursing home environment becomes all the more alarming in view of these statistics. In the past few years, there has been an effort on the part of state legislators to improve the nursing home environment, often taking the form of a patient

\(^{1}\) "Elderly" will be used in this Comment to represent the segment of the population age 65 or older.

\(^{2}\) This still holds true to a certain extent today, but the numbers change with age and vary according to sex. 79% of women live with families at age 55; 35.1% at ages 75 to 79; and only 13.9% above age 85. For men the decline is less steep with age. From ages 55 to 79, 85.1% reside with families; from 75 to 79, 72.0%; and over 85, 45.3% of men still live with families. Most older people who live in families are married and live with their spouse. J. Griffith, How Older Americans Live: An Analysis of Census Data 16 (Cong. Res. Service 1986).

\(^{3}\) The term "nursing home" will be used to include long term care facilities such as those discussed at notes 34 and 35 infra.

\(^{4}\) STAFF OF SENATE SPECIAL COMM. ON AGING, 99TH CONG., 2D SESS., NURSING HOME CARE: THE UNFINISHED AGENDA IV (Comm. Print 1986) [hereinafter NURSING HOME CARE].

\(^{5}\) Id.

“Bill of Rights.” These statutes outline minimum standards for health, safety, and patient autonomy. They have yet to be enacted in every state and even where enacted, the extent of enforcement varies. Consequently, there is a need for the enactment of a uniform statute establishing basic rights for residents of nursing homes.

This Comment will describe briefly the way in which the Medicaid program impacts on nursing home care. In addition, the Comment will suggest language for a model Nursing Home Act based on that found in existing state statutes.

**MEDICAID**

At any given time, sixty-seven percent\(^7\) of all nursing home residents receive federal and state assistance under Title IX of the Social Security Act (“Medicaid”).\(^8\) The Medicaid Program\(^9\) was enacted as part of the Social Security Amendments of 1965\(^10\), and came after many years of congressional debate.\(^11\) “Widespread poverty, an increased likelihood of costly episodes of illness, the apparent reluctance of the private insurance market to provide affordable protection, all created the moral basis for a social response to the health care needs of the elderly”.\(^12\)

In enacting Medicaid, Congress attempted to (1) provide the elderly with an adequate means of securing short and long term medical care and (2) to secure this medical care in such a way as to keep the system as cost effective as possible. At times, the effort to keep costs down has resulted in “poorly targeted reimbursements to some facilities . . . which force nursing home operators to cut corners on care.”\(^13\) This problem is exacerbated by the nursing home operator's desire to maintain a healthy profit margin.

*The Administration of Medicaid*

The Medicaid program is administered jointly by the federal government and participating states. In order to participate, a state must meet specific

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9. The purpose of the Medicaid Act was, in part, to provide “medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals whose income and resources are insufficient to meet the costs of necessary medical services . . .” 42 U.S.C. § 1396 (1984).
11. Id.
criteria embodied in the Medicaid statute. The Department of Health and Human Services ("HHS") oversees Medicaid's administration, including promulgating regulations under its authority. These regulations prescribe the federal obligations incumbent upon participating states and providers of medical services.

State participation in the Medicaid program is optional. To be eligible a state must submit a plan to HHS. The proposed plan must meet specific minimum federal standards and provide certain care services. States may, however, provide reimbursement for additional medical services, such as pharmaceuticals, at the state's option.

Despite the complicated network of procedures and standards associated with the Medicaid program, states have a great deal of latitude in its administration. States determine, among other things, the methods and rates of reimbursement for medical care, what constitutes a medically necessary procedure and minimum eligibility criteria.

An individual in need of medical care must meet basic income eligibility requirements to enroll in the Medicaid program. Generally, enrollees are either "categorically needy" or "medically needy": the former group represents those who receive or are eligible to receive aid in various federal assistance programs. While the latter group consists of those who may not be eligible for any form of federal assistance, but whose income is not sufficient to meet the cost of necessary medical services. Eligibility is determined largely by the states, which employ a variety of methods in making this determination.

Participating states have a substantial role in the administration of the Medicaid program. For example, a nursing facility must be certified by the

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15. Id.
16. Id.
19. Id. § 1396a.
20. Id. § 1396a(a)(10)(ii).
21. Id.
23. To say that Medicaid recipients receive benefits is somewhat deceiving. Recipients do not directly receive funds. Rather, the system is actually one of reimbursement by the federal and state government to the providers of medical care. See e.g., Blum v. Yaretsky, 457 U.S. 991, 994 (1982).
25. Id.
26. Id.
27. McKee v. Likins, 261 N.W.2d 566 (Minn. 1977).
responsible state agency to be eligible for reimbursement. In order to become certified, a facility must sign a provider agreement that establishes the scope of its obligation to both the state and federal agencies. Failure to comply with federally mandated requirements may result in decertification of the facility as a provider eligible for Medicaid reimbursement.

Compliance with Federal and State Regulations

Nursing homes must maintain specific standards to ensure the health and safety of its residents. These include establishing a governing body responsible for the operation of the facility, overseeing the patient's rights, and supervising the patient's medical care. The twenty-four hour nursing service requirement assures that patients receive medication, treatment, a proper diet, and are comfortable and fit. In addition, facilities are expected to maintain active programs for rehabilitative nursing care, assure that medications are administered only by state approved personnel, and that records are kept current as to all dealings with the patients.

29. Id.
30. Provided that income limits are not exceeded, Medicaid provides benefits for a stay of an unlimited duration (See Mendelson & Hapgood, supra note 22.) in a Skilled Nursing Facility (“SNF”) or Intermediate Care Facility (“ICF”). Under 42 U.S.C. § 1396d(f) “skilled nursing facility services” means “services which are or were required to be given to an individual who needs or needed on a daily basis skilled nursing care (provided directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis.” 42 U.S.C. § 1396d(c) specifies that an “intermediate care facility” is an “institution which . . . is licensed under State law to provide, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities.” Federal regulations require periodic review of a patient’s status in a certain facility, as a cost containment measure, to ensure that care is being received at the proper level given that person’s particular medical circumstances. 42 C.F.R. § 456.1 et seq. (1985). Such a determination is made by a Utilization Review Committee (“URC”) to ascertain whether a particular institution is providing the appropriate level of care. Factors considered in a utilization review include criteria established by the URC. HHS, Health Care Financing Administration-Utilization Control. 40 C.F.R. § 456 (1985). A URC’s finding that a resident is no longer in need of the level of care currently being provided at the SNF necessarily results in either the patient’s discharge or transfer to an ICF. A medical facility that fails to comply with these federally mandated requirements faces loss of their income from federal and state reimbursement for each resident affected.

31. NURSING HOME CARE, supra note 4, at 15-17. However, a recent case study of a fully certified SNF in Washington, D.C. revealed violations of all these requirements over a period of two years including lack of current physicals for 25 percent of patients, evidence of a high number of injuries from falls, incomplete nursing care plans, improper preparation of drugs, administration of drugs without prescription, no record of rehabilitative drug program, unsanitary kitchen conditions, therapeutic diets not followed to the extent that a diabetic’s tray
A nursing home that fails to comply with federal and state minimum health and safety standards requirements faces possible loss of its certification, and consequently reimbursement for its services.\(^2\)

Before a nursing home is decertified, however, it is entitled to a hearing\(^3\) and usually has the opportunity to correct existing violations. Ideally for the nursing home resident, problems are corrected at this stage. Once a final decision is made to decertify a nursing home, the problem becomes the placement of its Medicaid-dependent residents.

**PROTECTING RESIDENTS' RIGHTS**

As part of the Medicaid program,\(^3\) the federal government as well as many states have enacted a “Resident’s Bill of Rights” in an effort to safeguard the delivery of medical services and the individual rights of the elderly. The federal Resident’s Bill of Rights covers a broad range of areas, including, the right to be free from abuse, the right to consideration and dignity, and the freedom to socialize and pursue religious activities.

In the face of desperate need to protect resident’s rights it is commendable that the federal government and some state and local governments have adopted some form of patient’s bill of rights. Nonetheless, it is clear that there is little uniformity in the language or enforcement of these statutes.

The first step towards establishing a comprehensive federal policy on the rights of nursing home residents would be an evaluation of current statutes and programs, to determine how they could be coordinated to supplement the rights of the elderly. Specifically, the Older American’s Act\(^3\) (“OAA”) and other titles of the Social Security Act could help to address some of the existing problems and the American Association of Homes for the Aging (“AAHA”) has suggested the formation of a national advisory council to do just this. AAHA has recommended creation of a:

statutory National Advisory Council composed of state ombudsmen, state and local aging agencies, provider and consumer representatives, state regulators, health care professionals (physi-

...had two packages of sugar, medications kept in unsanitary containers, roaches throughout premises, dirty syringes used for tube feedings and numerous other violations. The committee noted that these conditions were present despite advance notice of inspections and previous notification of deficiencies. Id.

32. “[T]he basic Federal formula match ratio, i.e., its share of Medicaid payments for a given state is determined by a formula which incorporates the state's per capita personal income. The federal formula match ratio currently ranges from 50 to 78% with an estimated national average of 53%. 6 HEALTH CARE FINANCING REVIEW 24 (1984).
33. Hathaway v. Mathews, 546 F.2d 227 (7th Cir. 1976).
34. HHS, Patient’s Bill of Rights, 42 C.F.R. § 1121(K) (1985).
cians, nurses, administrators, social workers) and members of the general public to advise on administration, training, program priorities, development, research, and evaluation.\textsuperscript{36} Such a council could review and assess the effectiveness of different federal and state programs and thus enable legislators to more intelligently address the problems.

\textit{Model Legislation}

Although there is no comprehensive data on the problem it is still possible to develop preliminary guidelines for model legislation to promote nursing home residents' rights. First, because the OAA\textsuperscript{37} requires all fifty states and the District of Columbia to implement and maintain state agencies on aging and ombudsman programs, the OAA or the Medicaid Act could be amended to require adoption of a bill of rights conforming to certain minimum standards, such as those set out in the model bill in the appendix to this Comment. Alternatively, adoption of a state bill of rights for the elderly could be required by a separate Act. One advantage of this option is that such legislation could be applied to residents that receive Medicaid reimbursement and those who do not.

Existing statutes address patients' needs to varying extents. A model act should, however, incorporate the best of those provisions including those that (1) support self-determination and autonomy in patients' day-to-day lives, (2) provide for proper medical treatment, and (3) support continued placement in the nursing home. A mere grant of these rights, however, is practically ineffective without the addition of workable enforcement mechanisms.

At the time of this writing, more than half of the states and the District of Columbia have adopted patients' rights statutes.\textsuperscript{38} These rights both echo

\textsuperscript{36} American Association of Homes for the Aging, Comparison of IOM Recommendations, Long Term Care Survey (PACS), and Related Legislation 47 (June 1986).


and supplement the rights found under the federal Bill of Rights for patients. The legislative histories of these statutes indicate that concern over the denial of fundamental rights led these legislatures to enact such statutes. Most of the statutes emphasize that the rights enumerated are not exhaustive and represent only minimum guidelines for nursing home compliance.

Most statutes require that patients be informed of their rights prior to entering a nursing home and that a listing of these rights be posted in a prominent location. Other provisions apply to the whole array of residents' rights which can be categorized loosely as privacy, medical and transfer rights. Moreover patients are often accorded the right to present grievances with concomitant prohibitions of acts of retribution by those in charge of the nursing home.

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40. An example of legislative intent is found in DEL. CODE ANN. tit. 16, § 1121 (1983). It states "it is the intent of the General Assembly . . . to promote the interests and well-being of the patients and other residents in . . . nursing homes. It is declared to be the public policy of this state that the interests of the patient shall be protected by a declaration of a patient's rights, and by requiring that all facilities treat their patients in accordance with such rights."

Id.


Privacy Rights

Privacy rights are considered essential to the autonomy of each patient. Among the most basic manifestations of these rights is the privilege “to associate and communicate privately with persons of the resident’s choice.” Nevertheless, poor conditions in nursing homes create the need to spell them out. These rights echo those found in the federal Resident’s Bill of Rights as well as some fundamental rights of association found in the Constitution. Nevertheless, poor conditions in nursing homes create the need to spell them out.

Other rights which may be included under the rubric of privacy rights are the right to (1) confidential mail, (2) have access to a phone and speak (1)(6)(c) (1983); N.H. REV. STAT. ANN. § 151.21(V) (Supp. 1986); N.J. STAT. ANN. § 30:13-5(i) (West 1981); N.Y. PUB. HEALTH LAW § 2803-(3)(c) (McKinney 1985); N.D. CENT. CODE § 50-10.2-02(1)(c) (1987); OHIO REV. CODE ANN. § 3721.13(A)(29) (Baldwin 1982); OKLA. STAT. ANN. tit. 63, § 1-1918(B)(3) (West 1984); OR. REV. STAT. § 441.605(S) (1985); R.I. GEN. LAWS § 23-17.5-8 (1985); TEX. HUM. RES. CODE ANN. § 102.003(h) (Vernon Supp. 1987); VT. STAT. ANN. tit. 18, § 2101(5) (1984); WIS. STAT. ANN. § 50.09(b) (West Supp. 1986).


44. HHS, Patient’s Bill of Rights, 42 C.F.R. § 1121(K) (1985).


46. U.S. Const. amend. 1.

47. ARIZ. REV. STAT. § 36-447.17(A)(11) (1985); CONN. GEN. STAT. § 19a-550(a)(11) (Supp. 1987); DEL. CODE ANN. tit. 16, § 1121-26 (1983); FLA. STAT. ANN. § 400.022(b)
privately, \(48\) (3) privacy in one's room\(49\) and the right to privacy during visits for married residents or if both spouses reside in the home, the right to share a room, unless medically inadvisable.\(50\) The patient also has the right to use and retain his personal clothing and possessions, if space permits and the possessions do not interfere with the rights of other patients.\(51\) A competent


patient has the right to manage his financial affairs. Although if a patient is incompetent in this respect, the statute should provide that the resident and the guardian receive a statement of account.52 In addition, in response to some incidents where facilities were forcing residents to work, several legislatures inserted provisions to the effect that a patient has the right to refuse to perform services on behalf of the facility unless it is part of his therapy.53

Another provision that repeats a right created under the federal Resident's Bill of Rights and is found in most state statutes, is the right to be free from mental and physical abuse, and chemical and physical restraints.54


Although there are several definitions of abuse, all patients' rights statutes prohibit abuse, sometimes adding a provision that makes failure to report such abuse a misdemeanor. These provisions are designed to encourage reporting of these crimes, which despite these provisions often go unreported.

A complete statute should enumerate in some detail standards of care for nursing home residents and their concomitant right to privacy. Provision should be made to require that facilities establish specific written policies concerning hygiene, nutrition and activity programs. In addition, the statute should mandate that patients be notified of these obligations.

Medical Rights

A second broad category of rights relates to those that define each resident's role in his medical care. The first, a hybrid privacy and medical right supplies the right to privacy with regard to medical treatment and personal needs. In the close confines of a nursing home this right may often be subject to infringement. Similarly, related provisions should guarantee the confidentiality of a resident's personal and medical records; most com-

55. WASH. REV. CODE ANN. § 70.124.030 (1982).
56. "Residents either because of their advanced age, mental or physical infirmities or lack of financial resources are often unlikely to pursue costly... litigation... the expected time it would normally take to resolve the case frequently is longer than a resident's life expectancy." Harris v. Manor Health Care Corporation, 111 Ill.2d 350, 489 N.E.2d 1374 (1986).
57. See Appendix for additional rights.
59. supra note 42.
monly stipulating that only the patient or his guardian may release such records to a third party.

Patients also have generally the right to be informed of their medical condition and diagnosis, albeit the physician does have some discretion in this regard, and the opportunity to take part in the planning of their care and treatment. Some states specify that the patient be informed of the services available in the nursing home and its cost. A few states also provide that a patient may refuse treatment and medication after being fully informed of the consequences of such a decision. And reacting to incidents where geri-

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63. Id.


Atric patients were used to test experimental treatments and medications, some state legislatures have added the right to refuse to participate in medical experiments.\textsuperscript{66} Other states give a patient the prerogative to choose a personal physician and pharmacist.\textsuperscript{67} Together these statutes constitute a framework governing some of the most basic aspects of life in a nursing home, including medication and treatment. Moreover, many of these statutes extend these rights to a patient's guardian, so that even incompetent patients have an opportunity to have their interests represented.\textsuperscript{68}

\textit{Transfer Rights}

Nursing home residents who receive Medicaid benefits are dependent, in part, on the proper administration of the program and the state's enforcement of its regulations. Protecting a resident's rights may, ironically, complicate the enforcement of Medicaid regulations against nursing home operators. For example, a nursing home that is in violation of health regulations, can be decertified, which in turn, may necessitate the transfer of residents to another facility.

Thus the problem created is how to ensure that nursing homes comply with the applicable health and safety regulations under the Medicaid program and preserve the patient's right to remain in that nursing home. In \textit{Bracco v. Lackner}\textsuperscript{69}, a California case in which the decertification of a nursing home was at issue, forty-four needy, elderly patients brought suit claiming that their health and lives were endangered by an imminent cut-off of federal and state benefits, and hence transfer to another facility. Among the threats to the health of these patients recognized by the court was the "transfer trauma" such a relocation could cause, resulting in damage to individuals.

\textsuperscript{66} Id.

\textsuperscript{67} Id.

\textsuperscript{68} Id.

\textsuperscript{69} 462 F. Supp. 436 (N.D. Cal. 1978).
in terms of physical and emotional deterioration and increased mortality.\(^{70}\)

Although in *Bracco* the court found that relocation of nursing home residents would have adverse effects on their health, the results of studies on this phenomenon, commonly known as "transfer trauma," are somewhat mixed.\(^{71}\) Earlier studies on the topic strongly indicated that the elderly were much more likely to succumb to illness or death within a short time after the transfer.

Regardless of the actual statistics concerning "transfer trauma", moving from one residence to another, at any age, is a stressful event,\(^{72}\) and could be exacerbated when the individual, in this case a nursing home resident, has little or no control over the circumstances of the move. Moreover, nursing home residents are likely to develop personal ties within the nursing home, which for many residents, may be among the few social contacts they have which adds to the stress of being transferred. One commentator suggested that,

> [I]ike other kinds of social ties, friendship is considered precious by patients and residents. Friends spend much of their social lives together in various places at the Manor - morning until night, most days of the week. Those who are roommates are together around the clock. A change in such ties means a change in their lives.\(^{73}\)

In *O'Bannon v. Town Court Nursing Center*,\(^{74}\) the Supreme Court reversed a growing trend granting nursing home residents a hearing before a nursing home was decertified. At issue was whether the nursing home residents' constitutional due process rights were violated by failing to provide a federal or state hearing before the facility's Medicaid certification was revoked.\(^{75}\) A hearing would have enabled residents to have their concerns regarding potential transfer considered in the context of the decertification process. The Supreme Court, however, held that nursing home residents do not have the right to such a hearing prior to decertification.

An earlier Supreme Court decision, *Blum v. Yaretsky*,\(^{76}\) addressed the issue of whether state action existed when a nursing home, participating in the Medicaid program, transferred a patient without a pre-transfer hearing. The Court held there was no state action, finding that the complainant failed to demonstrate that the nursing home's actions could be considered an action

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70. Id. at 447.
75. Id. at 775.
by the state.\textsuperscript{77}

The result of the \textit{O'Bannon} and \textit{Blum} decisions denying patients the right to dispute a decertification determination on the basis of its effects on their health and well-being, is to allow the very regulations designed to protect nursing home residents to cause disruption, turmoil and perhaps threaten their lives. The court stated in \textit{O'Bannon} that:

the fact that the decertification of a home may lead to severe hardship for some of its elderly residents does not turn the decertification into a governmental decision to impose that harm \ldots because the enforcement by HEW and DPW of their valid regulations did not directly affect their legal rights or deprive them of any constitutionally protected interest in life, liberty or property.\textsuperscript{78}

Absent decertification proceedings, most statutes require that “a patient [be] transferred or discharged only for medical reasons, or for his welfare or that of other patients or for nonpayment of stay.”\textsuperscript{79} Often these statutes require reasonable notice to a patient prior to discharge or transfer in a non-emergency situation,\textsuperscript{80} however, the meaning accorded to the term “reasonable notice” varies significantly.

To address the problems, a model statute should attempt to prevent transfer trauma by supplying the patient with the right “to return to the first available bed in the nursing home he came from, after hospitalization, provided the facility is able to meet the patient’s medical needs and that the patient’s welfare or that of other residents will not be adversely affected.”\textsuperscript{81} Such a statute has the potential to ensure that patients hospitalized for a short duration will be able to return to the nursing home in which they were residing prior to being admitted to the hospital.

Model legislation should also incorporate a provision, such as Rhode Is-

\begin{itemize}
  \item \textsuperscript{77} \textit{Id.} at 1001.
  \item \textsuperscript{78} 447 U.S. at 772.
  \item \textsuperscript{80} \textit{Id.}
  \item \textsuperscript{81} \textit{See generally} \textit{Appendix.}
\end{itemize}
land's, which addresses transfer trauma indirectly by tackling the problem of nursing homes that discriminate against Medicaid patients in favor of private pay patients providing that:

Every patient who has been a resident of a nursing home which participates in Rhode Island's medical assistance program and has made payments from private funds for at least six months shall upon depletion of personal funds, be permitted to remain as a resident of said nursing home at the rate of payment to be paid by the Department of Social and Rehabilitation Services.⁸²

Receivership

In view of the previous discussion of transfer trauma, one of the more disturbing aspects of creating a viable method of reporting violations of a patient's right and guaranteeing that such violations will be addressed in the administrative, legislative and judicial arenas is that chronic violations will result in the closing of nursing homes and subsequent need to move patients. The concept of using receiverships as a means of keeping nursing homes open and in compliance with statutorily guaranteed rights dates back to 1971.⁸³ The first such provision appeared in 1974 and since then a number of states have adopted similar provisions.⁸⁴ The inclusion of this type of an enforcement mechanism is absolutely essential to the effectiveness of a resident's bill of rights at either the state or federal level. Such a provision was included in the 1985 version of the District of Columbia Nursing Home Act.⁸⁵ The Act outlines a comprehensive guide to (1) instituting receivership, (2) procedures for petitioning for receivership, (3) appointment of a receiver, (4) the receiver's qualifications and duties, and (5) the alternative of appointing a court monitor.⁸⁶ Receivership is the more drastic of these alternatives.

Under the District of Columbia receivership procedures corporation Counsel is designated to receive the initial complaint and file the petition for a receiver; although if he does not carry out the request the requestor may file the petition directly.⁸⁷ The nursing home may also apply voluntarily for

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⁸⁴. CONN. GEN. STAT. § 19a-541 - 9 (Supp. 1987); FLA. STAT. ANN. § 400.022(e) (West 1986); ILL. REV. STAT. ch. 111 1/2, para. 4152-201 (1977); KAN. STAT. § 39-954 - 9; N.Y. SOC. SERV. LAW §§ 461-f (McKinney 1985).
⁸⁵. NURSING HOME ACT § 32.1413(a)-(b).
⁸⁶. Id.
⁸⁷. Id. at § 32.1413(c).
a receiver. This procedure helps to ensure that petitions are filed by experienced counsel and only when other avenues, such as voluntary compliance, are exhausted, and ensures that no one organization is ultimately responsible. The court may act upon the petition immediately if "it finds probable cause to believe a condition on or practice in a facility poses an immediate danger of death or life threatening injury to the residents." If not, the statute provides for notice and discovery before hearing. The standard applied to appointing a receiver is clear and convincing evidence of grounds for receivership. Presumably, because the need for receivership may arise on very short notice, the statute contains a provision for establishing a list of potential receivers prior to such proceedings. Other provisions enumerate people who may have some type of conflict of interest with regard to the facility in question and provide for their replacement if necessary.

The statute details the powers and duties of the receiver and includes provisions for notice of receivership to the residents and others affiliated with the facility. Additionally, provision is made for obtaining funds both from regular sources and from a special revolving fund established for this purpose. The receiver's duty to the nursing home and the residents is consistent with the statutorily protected rights and includes the ability to cancel any obligations that may be unduly burdensome financially.

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88. Id. at § 32.1414(b)(1).
89. Id. at § 32.1415(a).
90. The Mayor shall, after consulting with appropriate District government agencies, the Long-Term Care Ombudsman, and representatives from nursing home and community residence facility providers, establish a list of potential receivers with experience in the delivery of health-care services, preferably in the operation of a nursing home or community residence facility.

91. Id. at § 32.1415(b)(3).
92. Id. at § 32.1415(d).
93. Powers and duties of receiver. (a) A receiver shall:

(1) Take charge of the operation and management of the facility and assume all rights to possess and use the building, fixtures, furnishings, records, and other related property and goods that the owner, licensee, or administrator would have if the receiver had not been appointed;

(2) Give notice of the receivership, in accordance with subsection (b) of this section, to the facility's residents and employees, each resident's representative, the Long-Term Care Ombudsman, and any other person whom the court orders should receive notice;

(3) Exercise his or her powers to correct all of the conditions that prompted the need for receivership, to ensure quality care for each resident, and to promote full respect for the rights of residents established by District and federal law.

94. Id. at § 32.1416.
95. Id. at § 32.1418.
In some cases, the court may appoint a court monitor rather than a receiver.\textsuperscript{96} The monitor observes the operation of the facility and advises it on how to comply with the law while reporting to the court at regular intervals. This is a less drastic and costly alternative and may be particularly useful in cases where the court finds that violations are a result of staff activities and not those of the administration.

The receiver’s job is a delicate one and there are some instances in which it may not be feasible to keep the facility open. In these instances the statute outlines a variety of means to ensure the safety and well-being of patients when the facility is closed and the need to transfer them arises.\textsuperscript{97} Notice, both oral and written, to the resident and resident’s advisor is required under the statute, as is the inclusion of extensive documentation of the reasons for changes in the resident’s records. A standardized written notice in large type is set out in the statute.\textsuperscript{98} Such careful wording and attention to detail are necessary in an area where those receiving notice may have some difficulty reading or comprehending the notice.

Requirements for notice and hearing, coupled with a mandate for careful documentation of all hearings and counseling sessions should be included in any state legislation. Record keeping is essential to monitoring the treatment of residents and the maintenance of their rights. All legislation should address these needs by requiring documentation of any complaints or changes in a patient’s treatment which differ from the norms set forth in the statute. This and a provision requiring that residents and their representatives be permitted access to medical and administrative records will facilitate later actions to bring facilities into compliance or to obtain damages.

Since many residents are frail, confused, or in some instances legally incompetent, it is imperative that any form of self representation, such as a residents council be supplemented by representation such as an ombudsman, patient’s advocate, guardian or other relative. Moreover, any actions taken

\textsuperscript{96} A monitor appointed under this section shall observe the operation of the facility, advise the facility on how to comply with District and federal law, and report periodically to the court. In each report to the court, the monitor shall make a recommendation on whether a receiver should be appointed for the facility. . . .

\textit{Id.} at § 32.140.

\textsuperscript{97} \textit{Id.} at § 32.1431.

\textsuperscript{98} [I]n addition to setting forth the procedures afforded the resident, the standardized written notice informs of the right to counseling: “To help you in your move, you will be offered counseling services by the staff, assistance by the District government if you are being discharged or transferred from the facility, and, at your request, additional support from the Long-Term Care Ombudsman program. If you have any questions at all, please do not hesitate to call one of the phone numbers listed below for assistance. . . .

\textit{Id.} at § 32.1432(d)(3).
on behalf of the residents must be reported to these representatives. As of 1978, amendments to the OAA require each state to set up an ombudsman program and to provide minimum funding for the program. Whether operating directly on behalf of a state agency or under a contract or other arrangement, the ombudsman is responsible for (1) the investigation and resolution of complaints made by or on behalf of the residents of long-term care facilities, (2) the monitoring of implementation of any federal state, or local laws impacting on long term care facilities, (3) the training of staff and volunteers to participate in the program, and (4) the gathering and reporting of information regarding problems that arise in the facilities to the public agencies by which they are regulated. By defining the term resident's representative to include not only the legal guardian, but also the long-term care ombudsman and any person designated by the resident and his with knowledge of his situation, the model statute makes representation possible for almost every resident.

It also allows monitoring of resident's rights by volunteers or family members and opens the door to a more cost effective method of overseeing the enforcement of rights. The name of each resident's representative is required to be in that person's records and posted in his room so that the representative may be contacted in an emergency.

The state ombudsman's office is empowered to set up a network of volunteer training facilities or sessions to supply nursing homes with regular visits by volunteers who can collect complaints, maintain files and seek relief if needed. This task can also be assumed by a properly trained local community organization, however, if facilities are in a position to expend the necessary funds, professionals such as social workers could also act as residents' representatives. If patient representatives visit a limited number of patients in every nursing home regularly, the residents must be advised of the timing and purpose of these visits, and granted short interviews with the representatives in order to facilitate reporting of problems within the nursing home. Providing patients and their representatives with the opportunity to develop a certain amount of rapport or trust is an essential element of any reporting mechanism because fear of reprisal and subsequent loss of housing are widely believed to discourage reporting. Thus at this stage emphasis must be placed on the importance of having independent representatives who do not rely on the facility for their livelihood and thus do not fear reprisal.

Once the resident's representative has received a complaint, one of two avenues may be pursued. If the complaint involves an immediate threat to

99. Id. at § 32.1401(11).
100. In Washington, D.C. the Washington Urban League, S.E. Cluster and Iona House fulfill this role.
the resident's physical or mental well-being, the representative may file a report directly with the nursing home asking the administrators to address the problem. If the problem is not rectified within a statutorily prescribed period, the violation may then be reported to an outside party. By requiring that the initial complaint keep the resident’s name confidential, the facility is given an opportunity to take swift remedial measures and the resident is protected. Also, it is possible that over a period of time, the resident’s representative and the nursing home staff may establish a working relationship. If compliance with a resident’s bill of rights were raised to the level of a condition of participation, violations would have serious repercussions, i.e., loss of certification. Thus, these complaints might have more of a chance of securing the attention that they deserve. Regular monitoring by resident’s representatives on an appointment, regular office hour or even an occasional surprise basis would be the most efficient forum for responsible oversight. Especially since in situations where seriously threatening conditions are present the representative is under a statutory duty to report the abuse in an individual as well as representative position.\textsuperscript{101}

\textit{Problems in Enforcement}

The latitude given physicians to limit or eliminate a patient’s rights when they believe from a medical standpoint that exercising that right is not in the patient’s best interest, further exacerbates the problem of maintaining these rights.\textsuperscript{102} This prerogative on the part of the physician may be open to abuse in certain situations. Some states attempt to curtail abuse by requiring the consent of two doctors to restrain or operate on a patient\textsuperscript{103} and/or by providing a patient with notice when the doctor recommends a transfer or discharge.\textsuperscript{104} Because a handful of doctors make decisions about the care required for a large number of nursing home patients there is a larger probability of noncompliance and difficulty in the review of the status of each patient’s rights.

The recipients of Medicaid are afforded some statutory protection against the infringement of their rights.\textsuperscript{105} The Medicaid statute provides that no recipient shall be denied benefits without prior notice and a hearing, and

102. An example is “a patient has the right to be fully informed about his condition unless medically contraindicated.” \textit{CONN. GEN. STAT.} § 19a-550(a)(11) (Supp. 1987).
104. \textit{Id.}
105. \textit{Id.}
may only be discharged for medical reasons.106 This provision appears to afford the nursing home resident little protection from being transferred to another facility in the event that their current home is decertified.

In *In re Smith*,107 Medicaid recipients in Colorado brought a class action against the Secretary of Health and Human Services ("the Secretary") alleging that the "Secretary has a statutory duty to develop an enforcement system whereby to receive Medicaid funds states would be forced to use a patient care management system."108 The court held that the Secretary had a duty to establish an enforcement mechanism consistent with the focus of the Medicaid Act, which is patient oriented rather than facility oriented.109 Upon recommendation by the court, the Secretary issued new regulations concerning nursing home inspection to ensure that federal standards are met.110

**Private Rights of Action**

The most expedient method of addressing violations of patient's rights is to allow the resident or his or her representative to maintain suit against the facility itself. The feasibility of this method is questionable, however, because a patient might fear or actually experience repercussions due to his complaint. Although in an extreme situation involving persistent violations, a receivership may be necessary, the need for individual remedies remains clear. In nursing homes with no state or federal funding, some form of injunctive relief or civil actions for damages may be the most effective way of addressing the problems in the facility. Moreover, when private actions can be brought independently of other remedies, they tend to work in tandem with other attempts at reform.111 And combination of administrative and judicial remedies decreases the chance that fear of repercussions or the lengthy litigation will deter the resident. It also increases the odds that the incident will be addressed.

There are three different private rights of action that the patient may pursue: (1) injunctive relief, (2) mandamus, and (3) civil action for damages.112

107. 747 F.2d 583 (10th Cir. 1984).
108. *Id.* at 587.
110. *Id.* at 6.
111. *Id.* at § 405.
Under the provision for injunctive relief, the resident, resident's representative, the regional Ombudsman or the Corporation Counsel may bring a Temporary Restraining Order or . . . (seek an) injunction to enjoin any violation. In the District of Columbia the individual or his representative may bring a mandamus action to compel the mayor or a government agency to comply with the existing law following notice of intent to bring the action. When strictly enforced, these options are likely to result in swift resolution of violations.

In nursing homes, as in other areas of society, individuals deserve the opportunity to seek redress for the wrongs they have suffered. A provision allowing a resident or resident's representative to bring an action to recover actual, punitive and/or treble damages when any standard is violated or retaliatory action is taken, must be part of any statute addressing residents rights. Although the expected duration of this type of litigation is a great deterrent to the elderly, when combined with other types of action it may place added pressure on the facility to conform.

It is also crucial that a patient rights statute address private rights of action, entitling the prevailing plaintiff to court costs and reasonable attorney's fees. This will work to ensure that litigation is an option for those elderly who do not have any income and reduces the burden on volunteer representatives.

Finally, for nursing home residents who are relatively isolated, the guarantee of protection of individual rights through their own action preserves essential aspects of the civil liberties and personal dignity they too should enjoy.

CONCLUSION

As the average age of the population increases and the cost of medical treatment rises, the need for wider implementation of patients' rights becomes imperative. Many states have thus far failed to enact statutes providing even the most basic rights. Plagued by problems of enforcement and implementation, existing state and federal statutes do not fulfill the promise of improving the quality of life and medical treatment in nursing homes. As


113. Nursing Home Act, § 32.1452.
114. Id. at § 32.1453(a).
115. Id. See generally, § 32.1453(a).
116. Id. at § 14.1454.
current statutes are amended and new ones added it is essential that the
proper tools be provided to make their goals a reality.

A myriad of surveys, proposals and studies have emerged from the various
state and federal agencies, congressional committees and private interest
groups. By combining the efforts and vast resources of these diverse groups
it is possible to create model legislation that will effectively and permanently
change the current status of the elderly in nursing homes today.

For patients rights legislation to succeed, certain rights must be included.
First, remedies available to nursing home residents must provide for the ex-
pedient resolution of claims and grievances. Aged residents should not be
forced to spend precious time awaiting response. Secondly, civil penalties
are necessary to give the providers of care the proper incentive to comply
with regulations. Current penalties, where they exist are often not suffi-
ciently onerous to be effective. Lastly, the residents themselves should be
given a greater voice in the operation of their homes. Increasing the amount
of control that residents have over their environment would be a major step
towards creating the type of atmosphere of self-reliance and dignity that the
elderly should not have to sacrifice as they step through the door of this
nation's nursing homes.

Epilogue

When this Comment was written in late 1986 and early 1987 several
surveys were being conducted on the conditions in nursing homes, but the
final versions were not available. While the statistics were compiled, the
administration finally acted on what had long been a sensitive issue by di-
recting HHS to issue proposed rules in October of 1987.\footnote{117} Despite the fact
that the HHS rules would greatly expand the rights of patients in nursing
homes and set higher standards for the quality of care,\footnote{118} Members of Con-
gress forged ahead in their efforts to pass detailed and comprehensive
amendments to both the Medicare and Medicaid acts. Representative John
D. Dingell, a Michigan Democrat, reflected the level of distrust on the part
of Members of Congress when he characterized the proposed rules as a
"death-bed conversion."\footnote{119} The amendments were signed into law on De-
cember 22, 1987 as part of the Omnibus Budget Reconciliation Act of 1987
and are aimed at providing services for residents of SNF's so that they may
"... attain or maintain the highest practicable physical, mental, and

October 16, 1987).
\footnote{118} Id.
psychosocial well-being."120

The reforms, which will take effect by late 1990, are modeled on the findings of the National Academy of Sciences in a study they conducted for HHS and are drafted in great detail.121 A "Bill of Rights" that included freedom of choice in the choice of a personal physician and plan of care, freedom from physical or mental abuse, and any chemical or physical restraints not part of the patient's treatment, privacy in the various aspects of everyday life, confidentiality of personal and clinical records and the accommodation of individual needs and preferences is one of the cornerstones of the new law.122 Residents of SNF's are also entitled to participate in resident and family groups and any social, religious or community activities that do not impinge on the rights of others; examine the results of the periodic surveys that will be conducted of the nursing homes under the new law; be informed of their rights and the services available to them; and voice any grievances that they may have to the State certification and survey agency.123 Separate provision is made to specify the manner in which resident funds are to be handled for their protection.124 Residents are not to be required to deposit their funds with the facility but if they choose to do so the facility must see that any amount of personal funds exceeding fifty dollars is deposited in an interest-bearing account; that a written record is kept of all transactions; that funds are conveyed promptly upon death; and that no charges are made to the account that will duplicate charges made under Medicaid or Medicare.125

Furthermore the SNF must assure that individuals seeking a place in the facility are not denied access to benefits or required to furnish a third party guarantee as a condition of admission.126 During their stay at the facility, the residents are allowed visits from any representative of the state, their personal physicians, family, legal representative, or other similar parties specified by the amendments who are not there against the patient's wishes without interference from the facility.127

Mindful of the trauma to patients when they are either transferred or discharged, the new law prohibits transfer or discharge unless it is deemed ap-

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120. H.R. 3545, 100th Cong., 2d Sess., 133 CONG. REC. 12,150, 12,156 (1987). (Since identical provisions will be added under both the Medicare and Medicaid Acts, cites are given to each with the Medicare provisions appearing first.)
121. N.Y. Times, supra note 144.
123. Id.
124. Id. at H12,152, H12,159.
125. Id.
126. Id.
127. Id.
appropriate for the resident's welfare as documented in the patient's record by a physician, the safety of other individuals in the facility is threatened, payments are not made for services that the resident requests, or the facility is closed.\textsuperscript{128} The resident is entitled to receive notice from the SNF of the impending transfer or discharge at least thirty days before the transfer occurs, except in cases where an immediate threat to the patient's life is involved.\textsuperscript{129} In addition, the resident should be informed of the right to appeal under a process to be established by the State and be provided with the state ombudsman's name, mailing address, and telephone number so that questions may be directed towards that office.\textsuperscript{130} If transfer or discharge is necessary, the facility must provide preparation and orientation for everyone affected.\textsuperscript{131}

Recognizing the diversity of patient needs in a setting such as a SNF, the new law requires that the SNF compile a resident assessment that evaluates the resident's capability to perform daily functions and present medical condition.\textsuperscript{132} By using a standardized form and examining the resident both upon admittance and at regular intervals thereafter, this procedure provides a way to assure that the plan of care is tailored to the individual's current needs.\textsuperscript{133} Civil money penalties are imposed on those who falsify the assessment which is to be conducted by a registered nurse in conjunction with a health professional.\textsuperscript{134} The quality of the assessments is also one of the criteria used in evaluating the overall performance of the nursing home in the annual survey.\textsuperscript{135} If repeated violations are found, an outside party may be brought in as an independent assessor.\textsuperscript{136}

In addition to the detailed provisions directed at the particular needs of residents as individuals, the amendments specify extensive regulation of the administration of SNF's and their personnel. Perhaps the most significant of these reforms are those that pertain to the training of the nurse's aides who provide the majority of direct care to residents. All nurse's aides will be required to undergo evaluations for competency, re-training or for those who are just entering the field, seventy-five hours of training is required. States are to maintain a nurse's aide registry where all nurse's aides are listed along with complaints about their treatment of patients and their exceptions to

\textsuperscript{128} Id. at H12,151-2, H12,158.
\textsuperscript{129} Id.
\textsuperscript{130} Id. at H12,152, H12,158.
\textsuperscript{131} Id.
\textsuperscript{132} Id. at H12,150, H12,156.
\textsuperscript{133} Id.
\textsuperscript{134} Id.
\textsuperscript{135} Id.
\textsuperscript{136} Id.
those charges. SNF’s are expected to consult the registry when hiring aides. In addition to providing around the clock licensed nursing care, SNF’s are required to provide for a registered nurse eight hours a day, seven days a week unless the state waives the requirement as not necessary for the needs of the residents of a particular home. Furthermore, facilities with more than one hundred and twenty beds must employ at least one full time social worker and all facilities must see that physicians supervise the care of residents.

The overall quality of nursing homes and their compliance with the law are to be managed using a two-tiered survey and certification process that is the responsibility of both the state and the federal government through the Secretary of HHS. States are to use survey teams composed of a multidisciplinary group of professionals including a registered nurse to conduct surveys. The surveys are all conducted on a surprise basis and a civil monetary penalty is imposed upon anyone who warns a facility that an inspection will be taking place. Standard surveys are to be conducted on an average of once every twelve months, but if violations are found, extended surveys are conducted when there is a change of ownership, administration or management in the facility. To see that states conduct these surveys accurately the Secretary of HHS will see that validation surveys are conducted in at least five percent of the facilities inspected within two months of the time the last state surveys were made.

States are required to investigate complaints and enforce actions against nursing homes that are found to be chronically substandard. The Secretary may provide for civil monetary penalties of up to ten thousand dollars for each day of noncompliance, deny payment of benefits, or institute temporary management of the facility depending on the severity of the violations and the time lapse between the discovery of a violation and compliance. If three years have passed and the facility continues to fail to meet the standards, payment must be withheld. The severity of this penalty becomes clearer when it is noted that the General Accounting Office has found that more than one-third of all nursing homes were substandard for three

137. Id. at H12,153, H12,259-60.
138. Id. at H12,154, H12,163.
139. Id. at H12,155, H12,165.
140. Id. at H12,154, H12,163.
141. Id.
142. Id.
143. Id. at H12,154-5, H12,163.
144. Id.
145. Id. at H12,155, H12,164-5.
years.\textsuperscript{146} If the violations are extensive enough to place the residents in immediate jeopardy, the Secretary has the choice of appointing a temporary manager or terminating participation entirely.\textsuperscript{147} Since violation of patient’s rights as well as violations of administrative procedures are regarded as non-compliance and the penalties can be so severe, these amendments promise to do a great deal for residents of nursing homes.

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\textsuperscript{146} N.Y. Times, \textit{supra} note 244.
\textsuperscript{147} H.R. 3545, 100\textsuperscript{th} Cong., 2d Sess., 133 CONG. REC. H12,156, H12,165.
APPENDIX

Nursing Home Model Act

LEGISLATIVE HISTORY

1-10-1 The responsibilities of nursing homes and a declaration of a bill of rights for such residents enunciated in this act hereof are declared to be the public policy of the state which is to protect the mental and physical welfare of the state's nursing home residents.

1-10-2 Each facility is responsible for the implementation of the resident's rights. To assure that the facility is abiding by this statute the local and state officials, defined below, will make routine and surprise inspections as well as respond to complaints.

DEFINITIONS

1-20-1 (a) ABUSE: (1) Physical abuse by intentionally and unnecessarily inflicting pain or injury to a patient or resident. This includes, but is not limited to, hitting, kicking, pinching, slapping, pulling hair or any sexual molestation; and (2) emotional abuse which includes, but is not limited to, ridiculing or demeaning a patient or resident, making derogatory remarks to a patient or resident or cursing directed towards a patient or resident, or threatening to inflict physical or emotional harm on a resident. 

(b) ADMINISTRATOR: Any person charged with the general administration or supervision of a health care, domiciliary or residential facility without regard to whether such person has an ownership interest in such facility or to whether such person's functions and duties are shared with one or more other person.

(c) AFFILIATE: (1) With respect to a partnership, each partner;

(2) With respect to a corporation, each officer and director and each stockholder who directly or indirectly owns or controls 10% or more of any class of securities issued by the corporation; and

(3) With respect to an individual:

(A) each parent, child, grandchild, spouse, sibling, first cousin, aunt, and uncle of the individual, whether the relationship arises by blood, marriage, or adoption; (B) each partnership in which the individual or an affiliate of the individual is a partner, and each other partner in that partnership; and (C) each corpora-
tion in which the individual or an affiliate of the individual is an officer, director, or stockholder who directly or indirectly owns or controls 10% or more of any class of securities issued by the corporation.

(d) COMMISSION: The state commission on aging.

(e) MEDICALLY CONTRAINDIKALED: A recommendation, clearly documented in a patient’s record, by at least two physicians familiar with the patient’s condition that a patient’s condition would deteriorate if the practice in question is not suspended or prohibited.

(f) NEGLECT: (1) Intentional lack of attention to physical needs of the patient or resident including, but not limited to toileting, bathing, meals and safety; (2) intentional failure to report patient or resident health problems or changes in health problems or changes in health condition to an immediate supervisor or nurse; and (3) intentional failure to carry out a prescribed treatment plan for a patient or resident.

(g) RESIDENT: Any person admitted to a long-term care facility as defined by this section.

(h) RESIDENTS’ REPRESENTATIVE: (1) any person who is knowledgeable about a resident’s circumstances and has been designated by that resident to represent him or her; (2) any person who has been appointed by a court or government agency either to administer a resident’s financial or personal affairs or to protect and advocate for a resident’s rights; or (3) the long term care ombudsman or his or designee, if no person has been designated or appointed in accordance with subparagraphs (A) - (B) of this paragraph.

1-30-1 Right to Receive Statement of Rights, rules, services and Charges - (a) All nursing homes shall adopt and make public a statement of the rights and responsibilities of the residents residing therein and shall treat such residents in accordance with the provisions of the statement. Each patient or their guardian shall receive a copy of such rights upon admission to such facility as evidenced by the patient’s or guardian’s written acknowledgment.

(b) Each facility shall post the rights and responsibilities in a conspicuous manner in locations generally available to patients.

1-30-2 All communication or correspondence should be in large legible type and read to both the resident and his or her guardian.
1-30-3 Each resident shall be informed in writing, prior to, or at the time of admission and during his or her stay, or services available and of related charges including all charges not covered either under federal and/or state programs, by other third payers or by the facility's basic per diem rate. A nursing care facility shall notify each resident of a proposed rate change.

FINANCIAL RIGHTS

1-40-1 Right to remain after depletion of funds - Every resident resides in a nursing home which participates in the state medical assistance program and has made payments from private funds for at least six (6) months shall upon depletion of the private funds, be permitted to remain as a resident of said nursing home at the rate of payment to be paid by and calculated by the department of social services, that is if the facility provides the level of care that the patient requires and has an available bed at that level of care. Every person or corporation violating this provision would be subject to a fine of up to five thousand dollars ($5,000) and/or loss of licensure.

1-40-2 Right to manage financial affairs - Every resident shall have the right to manage his or her financial affairs unless authority has been delegated to another pursuant to a power of attorney, or written agreement, or some other person or agency has been appointed for this purpose pursuant to law. Nothing shall prevent the resident and facility from entering into a written agreement for the facility to manage the resident's financial affairs. In the event that the facility manages the resident's financial affairs, it shall have an accounting available for inspection and shall furnish the resident with a quarterly statement of the resident's account. The resident shall have reasonable access to this account at reasonable hours. The resident or facility may terminate the agreement for the facility to manage the resident's financial affairs at any time upon five days notice.

PRIVACY RIGHTS

1-50-1 Right to be treated with consideration and respect - Each resident shall be treated with consideration, respect, and full recognition of his dignity and individuality.

1-50-2 Right to retain and use personal clothing and possessions - Each resident shall have the right to retain and use personal clothing
and possessions as space permits, unless to do so would infringe upon the rights of other residents or unless medically contraindicated as documented in the resident’s medical record by a physician. If clothing is provided to the resident, it shall be of reasonable fit. Upon request, the facility shall provide a means of securing the resident’s property in his room or in any other secured part of the facility so long as the resident has access to such property. Each facility shall keep a record of all personal property deposited within a secured part of the facility. The facility shall develop procedures for investigating complaints concerning thefts of resident’s property and shall promptly investigate all such complaints and report the results of the investigation to the complainant.

1-50-3 Right to private communications - Each resident shall enjoy the right to have unimpeded, private, and uncensored communication with anyone of the resident’s choice by phone, mail and visitation provided that the communication does not disturb other residents. The administration shall provide that mail is received unopened and mailed on regular postal deliveries, that telephones are accessible for confidential and private communications, and that at least one private communication, and that at least one private place per facility is available for visits during normal visitation hours. The resident also has the right to refuse any type of communications.

1-50-4 Right to consume alcohol - Each resident shall have the right to consume alcoholic beverages at his or her own expense, unless not medically advisable as documented in the resident’s medical record.

1-50-5 Right to use tobacco - Each resident shall have the right to use tobacco at his own expense under the home’s safety rules unless not medically advisable as documented in the resident’s medical record.

1-50-6 Right to choose when to rise and retire - Each resident shall have the right to retire and rise in accordance with his or her reasonable request, if it would not disturb others or the posted meal schedules and if the resident, upon the home’s request remains in a supervised area, unless not medically advisable as documented by the attending physician.

1-50-7 Right to participate in activities - Each resident shall have the right to participate in activities of social, religious and commu-
nity groups at the discretion of the resident unless medically contraindicated.

1-50-8  **Right to communicate in native language** - Each resident has the right not to be prohibited from communicating in his or her native language with other individuals or employees for the purpose of acquiring or providing any type of care, treatment, or services.

1-50-9  **Right of privacy for married persons** - Every resident who is married has the right to be assured of privacy for visits by his or her spouse. In addition, if both are residents in the facility then they have the right to share a room unless medically contraindicated.

1-50-10  **Right to present grievances and join with other residents to improve resident care** See col. 25-1-120 or fla 400.002

1-50-11  **Right to privacy in treatment** - Every resident has the right to have privacy in treatment and in caring for personal needs, to close room doors and to have facility personnel knock before entering the room, except in the case of an emergency or unless medically contraindicated, to have confidentiality in the treatment of personal and medical records. Privacy of a person's body shall be maintained during, but not limited to, toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance.

1-50-12  **Right to care without discrimination** - No licensed facility shall deny appropriate care on the basis of the resident's source of payment.

1-50-13  **Right to be free from abuse** - Each resident shall have the right to be free from mental and physical abuse, and to be free from chemical and physical restraints except as authorized in writing by a physician for a specified and limited period of time and documented in the resident's medical record. Physical restraints may be used in an emergency when necessary to protect the resident from injury from him or herself or others or to property. However, authorization for continuing use of the physical restraints shall be secured from a physician within twelve (12) hours. Any use of physical restraints includes, but is not limited to, any article, device or garment which interferes with the free movement of the resident and which the resident is unable to remove easily, and confinement in a locked room.

1-50-14  **Right to private communications** - A patient or resident is entitled to associate and have private communications and consultations
with his or her physician, attorney, family, or any other person of
his or her choice.

MEDICAL RIGHTS
1-60-1 Right to plan treatment - Each resident is entitled to participate in
planning his or her total care and medical treatment. Each resi-
dent shall be fully informed by his attending physician of his
medical condition and proposed treatment in terms and language
that the resident can understand.

1-60-2 Right to withhold payment to physician - Each resident has the
right to withhold payment for physician visitation if the physi-
cian did not visit the resident as scheduled.

1-60-3 Right to appropriate treatment - Each resident shall have the
right to receive adequate and appropriate medical care and to refuse
medication and treatment after being fully informed of and un-
derstanding the consequences of such actions.

1-60-4 Right to choose health care provider - Each resident shall have the
right to use the licensed, certified or registered provider of health
care, pharmacist and physician of the resident's choice

MISCELLANEOUS RIGHTS
1-70-1 Right to live in sanitary environment - Every resident has the right
to reside in a facility that is clean, sanitary, and in good repair at
all times. (cal. Sec. 1599.1)

1-70-2 Right to personal hygiene - Every resident shall show evidence of
good personal hygiene, be given care to prevent bedsores, and
measures shall be used to prevent and reduce incontinence for
each resident.

1-70-3 Right to quality food - Every resident shall be provided food of
the quality and quantity to meet the patient’s needs in accordance
with physicians orders.

1-70-4 Right not to perform services for the facility - No patient is to be
required to perform services for the facility that are not included
for therapeutic purposes in his or her plan of care.

IN Voluntary Transfer of Residents Discharged
From Facility; Return To Facility After
Transfer
1-80-1 (a) Except in an emergency, where the resident or other resi-
dents are subject to an imminent and substantial danger that only immediate transfer or discharge will relieve or reduce, a facility may involuntarily transfer a resident only in the following situations and after other reasonable alternatives to transfer have been exhausted:

(1) a physician determines that failure to transfer the resident will threaten the health or safety of the resident or others and documents that determination in the resident's medical record. If the physician determines that the facility cannot provide care, treatment, and services which are adequate and appropriate, it shall be conclusively presumed that the failure to transfer will threaten the health or safety of the resident. If the basis for the transfer or discharge is the safety of the resident, the resident shall not be involuntarily transferred or discharged unless a physician determines that such transfer or discharge is not reasonably expected to endanger the resident to a greater extent than remaining in the facility and documents that determination in the resident's medical records;

(2) the facility does not participate in or involuntarily ceases to operate or participate in the program which reimburses the cost of the resident's care;

(3) nonpayment of allowable fees has occurred. The conversion of a resident from private pay status to Medicaid eligibility due to exhaustion of personal financial resources or from Medicare to Medicaid does not constitute nonpayment of fees under this paragraph; or

(4) when the findings of a Medicare or Medicaid medical necessity review determine that the resident no longer requires the level of care provided at the facility.

(b) If the facility voluntarily or involuntarily ceases to operate or participate in the program which reimburses the costs of the resident's care, the facility must cooperate fully with the state Medicaid agency and the Ombudsman's regional office in the implementation of any transfer planning and transfer counseling conducted by these agencies.

(c) The facility shall assist the resident and guardian in finding a reasonably appropriate alternative placement prior to the proposed transfer or discharge. The plan for such transfer or discharge shall be designed to mitigate the effects of transfer stress to the resident. Such plan shall include counseling the resident,
guardian, or representative regarding available community resources and informing the appropriate state or social service organization.

(d) The facility must notify the resident, guardian or representative and attending physician at least thirty (30) days before any involuntary transfer, except a transfer pursuant to paragraph (4) of subsection (a) or this Code section. This notice must be in writing and must contain:

(1) the reasons for the proposed transfer;
(2) the effective date of the proposed transfer;
(3) notice of the right to a hearing and of the right to representation by legal counsel; and
(4) the location to which the facility proposes to transfer the resident.

(e) The resident shall receive at least fifteen (15) days' notice prior to an involuntary intrafacility transfer.

(f) If two residents in a facility are married and the facility proposes to transfer involuntarily on spouse to another facility at a similar level of care, the facility must give the other spouse notice of his or her right to be transferred to the same facility. If the spouse notifies a facility in writing that he or she wishes to be transferred, the facility must transfer both spouses on the same day, pending availability of accommodations.

(g) Each resident shall be discharged from a facility after the resident or guardian gives the administrator or person in charge of the facility notice of the resident’s desire to be discharged and the date of the expected departure. Where the resident appears to be incapable of living independently of the facility, the facility shall notify the county department of health services in order to obtain social or protective assistance for the resident immediately. The notice of the discharge by the resident or guardian, the expected and actual date thereof, and notice to the department, where required, shall be documented in the resident’s records. Upon such discharge and, if required, notice to the department, the facility is relieved from any further responsibility for the resident’s care, safety, or well-being.

(h) Whenever allowed by the resident’s health condition, a resident shall be provided treatment and care, rehabilitative services, and assistance by the facility to prepare the resident to return to
the resident's home or other living situation less restrictive, the facility shall provide him or her with information regarding available resources and inform him or her of the appropriate state or social service organizations.

(i) Each resident transferred from a facility to a hospital, or other health care facility, or trial alternative living placement shall have the right to return to the facility immediately upon discharge from the hospital or other health care facility or upon termination or the trial living placement. A resident who requests to return to a facility from a hospital shall be admitted by the facility to the first bed available after discharge from the hospital.

REPRESENTATIVE OF PATIENT; DEVOLUTION OF RIGHTS

1-90-1 Any rights under this chapter of a patient judicially determined to be incompetent, or who is found by his physician to be medically incapable of understanding such information, or who exhibits a communication barrier, shall devolve to such patient's guardian, conservator, next of kin, sponsoring agency, or representative payor, except when the facility itself is the representative payor.

OMBUDSMAN'S OFFICE; PATIENTS' ADVOCATE

1-90-2 Establishment of ombudsman's office - There is established a nursing home ombudsman office within the state department on aging which shall be responsible for receiving and resolving health and human services complaints affecting patients or residents in nursing home facilities as defined by the act. The commissioner shall appoint a state ombudsman and assistant regional ombudsmen, each of whom shall serve for terms coterminous with the term of the governor or until successors are chosen whichever is later. Such ombudsmen may not be removed, except for cause, which shall include, but not be limited to, misconduct, material neglect of duty or incompetence in the conduct of the office. Such state ombudsman and the regional ombudsmen shall appoint local volunteer residents' advocates, as provided by the act.

1-90-3 Residents' advocates - (a) Residents' advocates shall be appointed by the state ombudsman, in consultation with the regional ombudsmen, for each region in sufficient number to serve the nursing home facilities within such region. Such residents' advocates shall, if possible, be residents of the region in which they will serve,
and shall have demonstrated an interest in the care of the elderly. Residents' advocates shall serve without compensation but may be reimbursed for reasonable expenses incurred in the performance of their duties, within available appropriations.

(b) The residents' advocates shall be appointed after consultation with the chief administrative officer and the committee on aging, if any, for each town, the area agency on aging and the director of health serving each town and after submission of recommendations from at least two former employers or other nonrelated persons.

(c) The residents' advocates shall serve for a term of years specified by the commissioner on aging, provided a residents' advocate may be removed by the state ombudsman whenever he finds such residents' advocate guilty of misconduct, material neglect of duty or incompetence in the conduct of the office.

(d) Nothing in the act shall be construed to preclude the use of additional trained volunteers when it is deemed necessary to assist the state ombudsman, regional ombudsmen or the residents' advocates.

1-90-4 Residents' advocates: training requirement - (a) No person may perform any functions as a residents' advocate until he or she has successfully completed a course of training prescribed by regulation by the commissioner on aging. Any residents' advocate who fails to complete such a course within a reasonable time after appointment may be removed by the state ombudsman or the regional ombudsman for the region in which such residents' advocate serves.

(b) At the discretion of the commissioner on aging, after consultation with the state ombudsman the training requirement specified in subsection (a) may be waived upon a showing of adequate training or experience.

1-90-5 Duties of state ombudsman - The state ombudsman shall:

(1) establish program policies and procedures for receiving, evaluating, referring and resolving complaints from nursing home facility residents and families, employees of nursing home facilities and the general public, relating to nursing home facilities;

(2) carry out established policies and procedures, including receipt of appropriate complaints and reporting in writing on any action taken;

(3) collaborate with appropriate complaints and reporting in writing on any action taken;
(4) provide information as requested to state agencies and organizations;

(5) collect data for research and analysis to substantiate recommendations for policy and program changes and study the problems encountered therein;

(6) identify and document significant problems affecting a large segment of the nursing home facility population and communicate the documented problem area to groups or agencies with similar concerns and jurisdictional authority to deal with such problems;

(7) establish local liaison and working relationships with the media, speakers bureaus and civic organizations and develop an ongoing program of publicizing the ombudsmen office, its purposes and mode of operation, and

(8) submit legislative recommendations to the general assembly.

1-90-6 **Supervision of state ombudsman** - (a) The state ombudsman shall be under the direct supervision of and accountable to the commissioner.

(b) The state ombudsman is authorized to investigate and make reports and recommendations concerning any act or the failure to act by any agency, official or public employee, with respect to their responsibilities and duties in connection with nursing home facilities, except the courts and their personnel, legislative bodies and their personnel and the chief executive of the state and his personal staff and all elected officials.

1-90-7 **Duties of regional ombudsman** - The regional ombudsmen shall:

(1) be responsible for the residents; advocates in the performance of their duties and shall assist such advocates in resolving problems;

(2) investigate problems and complaints brought to them by such advocates and shall direct any complaint, so investigated, to the state ombudsman for further action, if necessary;

(3) collect data from their regions which shall be directed to the state ombudsman for research and analysis;

(4) carry out policies and procedures in their regions as established by the nursing home ombudsmen office, including reporting in writing any action taken concerning a complaint;

(5) collaborate with local and regional officials and organizations in attempting to clarify and resolve complaints; and

(6) establish local liaison and working relationships with the
media, speakers' bureaus and civic organizations and develop an ongoing program of publicizing the ombudsmen office, its purposes and mode of operation.

1-90-8 Duties of residents' advocates - (a) Residents' advocates, under supervision of the regional ombudsmen, shall assist the regional ombudsmen in the performance of all duties and responsibilities including, but not limited to, the following:

1. the establishment of program policies and procedures for receiving, evaluating, referring and resolving complaints from nursing home facility residents and families, employees of nursing home facilities and the general public, relating to nursing home facilities;

2. the carrying out of established policies and procedures, including receipt of appropriate complaints and the reporting in writing on any action taken;

3. the collaboration with state officials and other appropriate organizations to clarify complaints and the pursuit of all necessary steps to resolve such complaints;

4. the provision of information as requested to state agencies and organizations;

5. the collection of data for research and analysis to substantiate recommendations for policy and program changes and the study of the problems encountered therein;

6. the identification and documentation of significant problems affecting a large segment of the nursing home facility population and the communication of the documented problem area to groups or agencies with similar concerns and jurisdictional authority to deal with such problems;

7. the establishment of local liaison and working relationships with the media, speakers bureaus and civic organizations and the development of an ongoing program of publicizing the role of the state ombudsmen office and the residents' advocates;

8. the submission of legislative recommendations to the general assembly;

9. the facilitation of private legal action for residents if necessary;

10. assuring that the residents' bill of rights, as established in this act, is properly posted and is distributed to each resident or, if such resident is a minor or incompetent, to his relative, guardian, representative or sponsoring agency and assuring that all elements...
and provisions of the residents' bill of rights are adhered to properly;

(11) assuring that all mandated posting of the availability of reports has been complied with; and

(12) aiding residents in administrative procedures relating to transfers and discharges, and aiding in ensuring that residents are satisfied with the management of their financial affairs.

(b) Such residents advocates shall report to the commissioner and to the local directors of health or the equivalent.

(c) All nursing home facilities shall post or cause to be posted in a conspicuous place therein a list of the names of the appropriate residents' advocates and the names, addresses, and telephone numbers of the appropriate ombudsmen.

(d) The commissioner on aging shall have authority to seek funding for the purposes contained in this section from public and private sources, including but not limited to federal or state funded programs.

1-90-9 Review of report or complaint - Upon receipt of a report or complaint as provided in this act, the ombudsmen shall determine immediately whether there are reasonable grounds for an investigation. If it is determined that reasonable grounds do not exist for an investigation, the complainant or the person making the report shall be notified of this determination within five working days after the receipt of such complaint or report. If such reasonable grounds are found, the appropriate regional ombudsman in conjunction with the residents advocates, shall investigate such report or complaint within ten working days thereafter. The regional ombudsman shall complete his investigation and make a report of his findings, within fifteen working days after the receipt of the complaint or report, a copy of which shall be sent to the state ombudsman. If the investigation indicates that there is a possible violation of the provisions of the public health code with respect to licensing requirements, the regional ombudsman shall refer the report or complaint, together with a report of his investigation, to the commissioner for appropriate action under the act. If no violation of the public health code is indicated, the regional ombudsman shall take whatever action he deems necessary, and shall notify the complainant or the person making the report, of the action taken within fifteen working days after receipt of the complaint or report.
1-90-10 Civil immunity of state employees - Neither the state ombudsman, nor any employee of the nursing home ombudsmen office, nor the regional ombudsmen, residents' advocates or any employee of any other state agency shall be held personally liable in any civil action for damages on account of any act or omission not wanton nor wilful in the performance of his or her responsibilities or duties under this act. Any person to whom the provisions of this section apply and against whom any action is brought on account of any alleged act or omission shall be represented therein by the attorney general.

1-90-11 Penalty for failure to cooperate with ombudsman or residents' advocate - (a) Any nursing home facility which refuses to permit the state ombudsman or any regional ombudsman or any residents' advocate entry into such facility or refuses to cooperate with the state ombudsman, or any regional ombudsman or any residents' advocate in the carrying out of their mandated duties enumerated in the act or refuses to permit residents or staff to communicate freely with the state ombudsman or any regional ombudsman or any residents' advocate shall be subject to a penalty.

(b) In carrying out their duties, the state ombudsman, the regional ombudsmen and the residents' advocates shall have access to all relevant public records, except that records which are confidential to a resident shall only be divulged with the written consent of the resident.

(c) In the performance of the duties and responsibilities enumerated in the Act, the state ombudsman, the regional ombudsmen and the residents' advocates may utilize any other state department, agency or commission or any other public or private agencies, groups or individuals who are appropriate and who may be available.

1-90-12 Regulations - Regulations shall be promulgated by the commissioner on aging to carry out the provisions of this act.

1-90-13 Annual report - The state ombudsman shall submit, through the commissioner on aging, a report to the governor and the general assembly of the activities of the ombudsmen office during the prior fiscal year and a projected budget for the coming fiscal year. The report shall include, but not be limited to, the number and general pattern of complaints received by the ombudsmen office, the number and nature of administrative acts investigated, the action taken on such investigations, the results of such actions
and any opinions or recommendations which will further the state’s capabilities in resolving nursing home complaints.

1-90-14  Advisory council on aging - There shall be an advisory council on aging consisting of twenty-one members. The commissioner on aging shall be an ex-officio member of said council without vote.

CIVIL ENFORCEMENT OF RESIDENTS’ RIGHTS

1-100-1  Any resident whose rights as specified in this chapter are deprived or infringed upon shall have a cause of action against any facility responsible for the violation. The action may be brought by the resident or guardian, by a person or organization acting on behalf of a resident with the consent of the resident or guardian, by an ombudsman, or by the personal representative of the estate of a deceased resident when the cause of death resulted from the deprivation or infringement of the decedent’s rights. The action may be brought in any court of competent jurisdiction to enforce such rights and to recover actual and punitive damages for any deprivation or infringement on the rights of a resident. Any plaintiff who prevails in any such action may be entitled to recover reasonable attorney’s fees, costs of the action, and damages. The remedies provided in this section are in addition to and cumulative with other legal and administrative remedies available to a resident and the department.

FACILITY’S RESPONSIBILITY FOR REVIEWING COMPLAINTS

1-110-1  (a) Each facility shall establish a system of reviewing complaints and allegations of violations of residents’ rights established under this section. The facility shall designate a specific individual who, for the purpose of effectuating this section, shall report to the administrator.

(b) Allegations of violations of such rights shall be promptly reported by the facility to the appropriate licensing or examining board and to the person against whom the allegation has been made.

(c) No person who files a report as required in paragraph (b) or who participates, in good faith, in the review system established under paragraph (a) shall be liable for civil damages for such acts.

(d) The facility shall attach a statement, which summarizes complaints or allegations of violations of rights established under
this section, to an application for a new license or a renewal of its license. Such statement shall contain the date of the complaint or allegation, the name of the persons involved, the disposition of the matter and the date of disposition. The department shall consider such statement in reviewing the application.

(e) Complaints filed on behalf of residents pursuant to this act shall take precedence over other court business unless the court determines that some other pending proceeding, having similar statutory precedence, shall have priority. A hearing shall be conducted within five days of the filing of the petition, at which time all interested parties shall have the opportunity to present evidence pertaining to the petition. Every reasonable effort should be made to resolve the dispute within six months of the filing of the complaint.

1-110-2  
Mandamus - A resident, a resident's representative, the Ombudsman, or the licensee or administrator of a facility may bring an action in court for mandamus to order the commissioner or any state government agency to comply with this act, any rule issued by the commissioner pursuant to the act, or any other state or federal law relevant to the operation of a facility or the care of its residents. Any person bringing an action under this section shall give the commissioner at least five days' advance notice (excluding Saturdays, Sundays and legal holidays) before the action is filed in court.

RESIDENTS' ADVISORY COUNCIL

1-120-1  
(a) Each facility shall establish a resident's advisory council. The administration shall designate a member of the facility staff to coordinate the establishment of and tender assistance to, said council.

(b) The composition of the resident's council shall be varied but no employee or affiliate of a facility shall be a member of any such council.

(c) The resident's advisory council shall meet at least once each month with the staff coordinator who shall provide assistance to said council in preparing and disseminating a report of each meeting, as specified by the regulations, to all residents, the administrator and the staff.
(D) Records of the residents' advisory council meeting shall be maintained in the office of the administrator.

(E) The residents' advisory council shall communicate to the administrator the opinions and concerns of the residents. The council shall review procedures for implementing residents' rights, facility responsibilities and make recommendations for changes or additions which will strengthen the facility's policies and procedures as they affect residents' rights and facility responsibilities.

(F) The resident's advisory council shall be a forum for:
   1. Obtaining and disseminating information
   2. Soliciting and adopting recommendations for facility programming and improvements, and
   3. Early identification and recommendation of orderly resolution of problems.

(G) The resident's advisory council may present complaints to the Commission.

RECEIVERSHIP

1-130-1 Purpose - The purpose of a receivership authorized under this title shall be to safeguard the health, safety, and welfare of a facility's residents when seriously endangered, to ensure their continuity of care, to safeguard their rights as recognized by State and federal law, and to protect them from the increased stress and risk of trauma often associated with abrupt or unplanned transfer and discharge. A receiver appointed under this title shall not take any actions or assume any responsibilities inconsistent with this purpose. Nothing in this title shall be construed to limit or abrogate any other common law or statutory right to petition for receivership.

1-130-2 Grounds for receivership - A receiver may be appointed under this title on one or more of the following grounds:
   (1) the facility is unlawfully operating without a current license;
   (2) the licensee has abandoned the facility;
   (3) the licensee is closing the facility or has informed the department that it intends to close the facility and adequate arrangements have not been made for relocation of the residents
within 7 days, exclusive of weekends and holidays, of the closing of the facility;

(4) a condition or practice in the facility poses a serious, widespread danger, either immediate or recurring, to the health, safety, or welfare of the residents;

(5) violations of residents' rights, established pursuant to this Act, are chronic, substantial, and widespread; or

(6) the licensee cannot meet its financial obligation for providing food, shelter, care, and utilities. Evidence such as the issuance of bad checks or an accumulation of delinquent bills for such items as personnel salaries, food, drugs or utilities shall constitute prima facie evidence that the ownership of the facility lacks the financial ability to operate the home in accordance with the requirements of this part and all rules promulgated hereunder.

1-130-3 Petitions for Receivership - (a) Notwithstanding the availability of any other remedy, the representative may, in the name of the state and based on one or more of the grounds listed in section 1-90-2 above, petition the court to appoint a receiver for any facility.

(b) Notwithstanding the availability of any other remedy, a resident, a resident's representative, the ombudsman, or any other advocate representing the interests of a facility's residents may, based on one or more of the grounds listed in section 1-130-2 (2) through (6), submit a written request asking the representative to petition the court to appoint a receiver for any facility. If the representative denies the request or does not file a petition within five days (excluding Saturdays, Sundays, and legal holidays) after receiving a request, the requestor may file with the court a petition for the appointment of a receiver.

(c) The licensee of any facility may, based on one or more of the grounds listed in section 1-90, petition the court to appoint a voluntary receiver for that facility.

1-130-4 (a) Petitions for receivership shall take precedence over other court business unless the court determines that some other pending proceeding, having similar statutory precedence, shall have priority. A hearing shall be conducted within five days of the filing of the petition, at which time all interested parties shall have the opportunity to present evidence pertaining to the petition.
(b) The petitioner (if he or she is not the licensee) shall ensure that the licensee or administrator of the facility is served with notice of the hearing date and a copy of the petition:

(1) in accordance with court rules at least five days (excluding Saturdays, Sundays, and legal holidays) before the hearing; or

(2) by a notice conspicuously posted inside or on the front door of the facility at least three days (excluding Saturdays, Sundays, and legal holidays) before the hearing, if the petitioner files with the court a sworn statement setting forth in detail his or her diligent but unsuccessful efforts to find the licensee or administrator and serve process.

(c) Upon filing a petition with the court, a petitioner other than the state shall serve notice of the hearing date and a copy of the petition on the _________. No later than five days (excluding Saturdays, Sundays, and legal holidays) after receiving a copy of the petition, the ________ shall, to the extent allowable under federal law, make available to the petitioner for his or her use in the proceedings certified copies of all licensure and Medicare/Medicaid certification reports within the custody of the state government that document conditions in the facility within the previous two years.

(d)(1) The court may appoint a receiver immediately upon the filing of a petition under section 1-90-3 if it finds probable cause to believe a condition or practice in a facility poses an immediate danger of death or life-threatening injury to the residents.

In the event of an ex parte appointment under paragraph (1) of this subsection, the petitioner (if he or she in not the licensee) shall ensure that the licensee or administrator of the facility is served with notice of the hearing date and copies of the petition, any supporting affidavit(s), and the order of appointment:

(A) by personal service within twenty-four hours after the appointment; or

(B) by a notice conspicuously posted inside or on the front door of the facility within forty-eight hours after the appointment, if the petitioner files with the court a sworn statement setting forth in detail his or her diligent but unsuccessful efforts to find the licensee or administrator and serve process.

1-130-5

Appointment of receiver; continuation of ex parte appointment -

(a) After a hearing the court may appoint a receiver for the facil-
ity or continue the appointment of a receiver made ex parte if it finds that the petitioner has proven, by clear and convincing evidence, the existence of one or more of the grounds for receivership listed in section 1-130-2.

(b)(1) The regional ombudsman shall, after consulting with appropriate State government agencies, the local Ombudsman, and representatives from nursing home and community residence facility providers, establish a list of potential receivers with experience in the delivery of health-care services, preferably in the operation of a nursing home or community residence facility.

(2) Except as provided in paragraph (3) of this subsection, the court may appoint as a receiver any qualified person with experience in the delivery of health-care services, preferably in the operation of a nursing home or community residence facility. In deciding whom to appoint, the court shall give strong consideration to the list of nominees established pursuant to paragraph (1) of this subsection.

(3) The court shall not appoint as a receiver; (A) An employee of a state or local government agency that licenses, operates, or provides a financial payment to, the type of facility being placed in receivership; (B) The owner, licensee, or administrator of the facility, or an affiliate of the owner, licensee, or administrator; or (C) A parent, child, grandchild, spouse, sibling, first cousin, aunt, or uncle of one of the facility’s residents, whether the relationship arises by blood, marriage, or adoption.

(c)(1) Before a receiver takes charge of a facility, he or she shall file a bond with the court that; (A) does not exceed the value of the facility and its assets; and (B) runs to the District for the benefit of all persons interested in his or her faithful performance of the receivership

(2) Unless the court directs otherwise, the receiver may pay the premium of the bond from the facility’s income.

(d) Any person authorized to file a petition under section 1-90-3 may petition the court to appoint a substitute for a receiver who:

(1) Dies;

(2) Has or develops a disability that impedes his or her ability to carry out the receivership;

(3) Has or develops a conflict of interest; or
Powers and Duties: (a) A receiver shall:

(1) take charge of the operation and management of the facility and assume all rights to possess and use the building, fixtures, furnishings, records, and other related property and goods that the owner, licensee, or administrator would have if the receiver had not been appointed;

(2) give notice of the receivership, in accordance with subsection (b) of this section, to the facility's residents and employees, each resident's representative, the Ombudsman, and any other person whom the court orders should receive notice;

(3) exercise his or her powers to correct all of the conditions that prompted the need for receivership, to ensure quality care for each resident, and to promote full respect for the rights of residents established by state and federal law;

(4) unless the facility is closing, take all steps necessary to maintain or restore state licensure and federal Medicare/Medicaid certification;

(5) preserve all property and records with which he or she is entrusted;

(6) report to the court in accordance with a schedule established by the court;

(7) carry out any other duties established by the court.

(b) The notice required by subsection (a)(2) of this section shall include at a minimum the following information in not less than 12 point type:

(1) the reasons for and purpose of the receivership;

(2) the identity of the receiver and how he or she may be contacted;

(3) the anticipated duration of the receivership; and

(4) unless the receiver was appointed to facilitate the orderly transfer or discharge of residents, a statement in boldface making clear to the residents that they do not have to move.

(c) Whenever a resident is to be discharged, transferred, or relocated, a receiver shall:

(1) comply with all provisions of this Act;

(2) explain to the resident and residents' representative the alternative placements that are available, help them find an ap-
proper alternative placement, and provide them with information about the alternative placement chosen;

(3) transport the resident to the alternative placement chosen; and

(4) transfer all property of and records pertaining to the resident, including all necessary health information, to the resident, resident's representative, or appropriate authority at the alternative placement.

(d) A receiver may:

(1) use in a reasonable and prudent manner all private and third-party payments to the facility, including payments made under Medicare or Medicaid and, with the approval of the court, money from the special fund or account if established under section 1-130-9.

(2) enter into contracts and hire agents, consultants, and employees to carry out the powers and duties established by this section;

(3) direct, manage, and discharge employees of the facility, subject to State law and any contract rights they may have; and

(4) exercise any other powers authorized by the court.

(e) If the structural, architectural, or environmental conditions of a facility violate state or federal law or otherwise endanger the health, safety, or welfare of the residents, the receiver may correct the violation:

(1) without the consent of the court, if the cost of the correction does not exceed $5,000; or

(2) upon court approval of a written estimate and plan of correction, if the cost of the correction exceeds $5,000.

(f) Except as provided in paragraphs (2)-(6) of this subsection, a receiver shall honor all leases, mortgages, secured transactions, and other contracts related to the facility and its operation.

(2) a receiver shall assume all rights to enforce or avoid the terms of a lease, mortgage, secured transaction, or other contract related to the facility and its operation that the owner, licensee, or administrator would have if the receiver had not been appointed.

(3) a receiver shall not be required to honor a lease, mortgage, secured transaction, or other contract related to the facility and its operation if the obligee is, or at the time the obligation
(4) A receiver may petition the court to allow him or her to wholly or partially avoid the terms of a lease, mortgage, secured transaction, or other contract that the licensee or administrator of the facility entered into if those terms provide for a rent, interest rate, or other payment substantially in excess of an amount that was reasonable at the time the contract was entered into, or if performance of the contract would substantially impede the receiver's ability to carry out the purposes of the receivership. 

(5)(A) the court shall hold a hearing on a petition filed under paragraph (4) of this subsection within fifteen days (excluding Saturdays, Sundays, and legal holidays) after it is filed. 

(B) the receiver shall ensure that, at least ten days (excluding Saturdays, Sundays, and legal holidays) before the hearing, notice of the hearing date and a copy of the petition are served in accordance with court rules on all persons whose legal or beneficial interest in the contract at issue is ascertainable with reasonable diligence. 

(6) if the court finds that the receiver has proven the averments in the petition by clear and convincing evidence, it may, for the duration of the receivership, excuse performance of the contract or adjust the rent, interest rate, or other payment under the contract to and amount that was reasonable at the time the contract was entered into. 

(7) compliance with a court order issued under paragraph (6) of this subsection shall be a defense to any action brought against a receiver alleging breach of contract. The receiver's compliance with a court order, however, shall not relieve the licensee or administrator of the facility of his or her liability for the difference between the amount paid by the receiver and the amount originally due under the contract. 

(g) A receiver shall be personally liable only for his or her acts of gross negligence or intentional wrongdoing in carrying out the receivership. 

(h) A receiver shall be entitled to a reasonable fee established by the court to be paid from the revenues of the facility.

Termination of receivership - (a) Except as provided in subsection (b) of this section, a receivership shall terminate when:
(1) the person who will assume control of the facility has been granted a current license by the state and:

   (A) the time period specified in the order appointing the receiver elapses and is not extended; or (B) the court determines the receivership is no longer necessary because the grounds on which it was based no longer exist; or

(2) the facility is closing and all of its residents have been transferred or discharged.

(b)(1) Notwithstanding subsection (a) of this section, a receivership of a private facility shall not be terminated in favor of any person who was the licensee or administrator in favor of any person who was the licensee or administrator at the time a petition was filed under section 1-90-3, or, in the discretion of the court, any person who is or was an affiliate of the licensee or administrator, unless he or she first:

   (A) reimburses the District government for any increase in Medicaid expenditures needed to finance the receiver's bond premium, to pay the receiver's fee, or to correct deficiencies caused by the licensee's or administrator's own negligence; and
   (B) reimburses the District government for any amount it loaned the receiver for major repairs or improvements to the facility, or assumes an obligation to repay the loan and provides collateral or other assurance of payment deemed sufficient by the state.

(2) the court may in addition require that, before a person specified in paragraph (1) of this subsection resumes control of a facility, he or she post bond in an amount it deems appropriate as security against future noncompliance with the law. If the receivership is not reinstated under subsection (c) of this section, the bond money shall be returned.

(c) Should it appear that, within two years after a receivership is terminated in favor of a person specified in subsection (b)(1) of this section, that person is not maintaining the facility in substantial compliance with all applicable laws, and should the court so find after granting notice and a hearing to all parties to the earlier receivership proceeding, the previous order appointing a receiver may be reinstated. A receiver thus reappointed may use all or part of any bond posted pursuant to subsection (b)(2) of this section to remedy the deficiencies.

1-130-8 Final accounting - Within 30 calendar days after termination of a receivership, the receiver shall give the court a complete account-
ing of all property with which he or she has been entrusted, all funds collected, and all expenses incurred.

1-130-10 Special fund or account - (a) The state may establish a special revolving fund or a separate allocable revenue account in the general fund to provide financial support in the form of loans to a receiver of a facility. If established, this fund or account may be supported in accordance with subsection (f) of this section.

(b) For the purpose of this section, the term “fund” means the special revolving fund or separate allocable revenue account referred to in subsection (a) of this section.

(c) If expenses remain unpaid after a receiver uses all private and third-party payments, the receiver may petition the court for money from the fund. Before the court authorizes use of money from the fund, it shall hold a hearing at which the regional Ombudsman, the receiver, the licensee, the owner, and the administrator of the facility may offer evidence on whether the court should approve the loan. Notice of the hearing shall be given to the regional Ombudsman, the receiver, the licensee, the owner, and the administrator of the facility at least seven days (excluding Saturdays, Sundays, and legal holidays) before the hearing.

(d)(1) A loan from the fund shall create an automatic lien on the facility and its assets in the amount of the loan. The receiver shall file with the regional Ombudsman a document setting forth:

(A) the amount of the loan;

(B) the name of the facility to which the lien attaches; and

(C) a description of the assets of the facility that are affected by the lien.

(2) a lien created under this subsection shall:

(A) extend to the property of the facility described in the document filed under paragraph (1) of this subsection and to the beneficial interest in that property possessed by the owner; and

(B) have priority over any other lien or interest that attaches after the filing date, except as otherwise provided by federal law.

(e) In addition to receivership loans, the regional Ombudsman may use money form the fund for low-interest loans or grants to
facilities to help improve resident care, address the personal needs of residents, and enhance resident safety.

(f) The regional Ombudsman may support the fund with money received from:

(1) the collection of civil fines, penalties, and related costs imposed against a facility;

(2) the sale of properties subject to liens created by this section;

(3) the assessment of facility licensure fees; and

(4) the repayment of loans made under this section. (g) Any money in the fund in excess of $500,000 shall revert to the General Fund.

1-130-10 Appointment of court monitor - (a) Any person authorized to file a petition for receivership may, based on one or more of the grounds listed in section 1-130-2, petition the court for the appointment of a monitor. In addition, in lieu of appointing a receiver when a petition for receivership has been filed, the court may, on either its own motion or the motion of a party, appoint a monitor instead. The grounds and procedures set forth in sections 1-130-2 through 1-130-5, except for the requirement of a bond, shall apply to the appointment of a monitor. The appointment of a monitor may be terminated by the court for any of the reasons listed in section 1-130-7(a) or if the court determines that a receiver should be appointed.

(b) A monitor appointed under this section shall observe the operation of the facility, advise the facility on how to comply with state and federal law, and report periodically to the court. In each report to the court, the monitor shall make a recommendation on whether a receiver should be appointed for the facility.

(c) Whenever a person requests the regional Ombudsman to petition for the appointment of a receiver under section 1-130-3(b) and the regional Ombudsman instead petitions the court for the appointment of a monitor, the request shall be considered denied and the requestor may petition the court for the appointment of a receiver.

1-130-11 Nothing in this section shall be deemed to relieve any owner, administrator, or employee of a facility placed in receivership of any civil or criminal liability incurred, or of any duty imposed by law, by reason of acts or omissions of the owner, administrator, or
employee prior to the appointment of a receiver; nor shall any-
thing contained in this section be construed to suspend during the
receivership any obligation of the owner, administrator, or em-
ployee for payment of taxes or other operating and maintenance
expenses of the facility, or of the owner, administrator, employee,
or any other person for the payment of mortgages or liens. The
owner shall retain the right to sell or mortgage any facility under
receivership, subject to approval of the court which ordered to
receivership.

REPORTING OF ABUSE, NEGLECT OR EXPLOITATION

1-140-1  (a) When, while acting in his professional capacity, a physician,
intern, medical examiner, physician's assistant, registered or li-
censed practical nurse, social worker, psychologist, pharmacist,
or physical therapist suspects that a resident has been abused,
neglected or exploited, then the professional shall immediately re-
port or cause a report to be made to the Department of Health.

(b) Whenever a person is required to report in his capacity as a
member of the facility staff, he or she shall immediately notify the
person in charge of the facility, who shall then cause a report to
be made.

(c) Reports regarding abuse, neglect or exploitation shall be
made immediately by telephone to the Department of Health and
shall be followed by a written report within forty-eight (48) hours
if requested by the department. The reports shall contain the
name and address of the resident; information regarding the na-
ture and extent of the abuse, neglect or exploitation; the source of
the report; the person making the report; his occupation; and
where he can be contacted.