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Understanding and Implementing Resident's Rights

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Introduction

Residents of health care facilities have specific rights protected by law. Health care professionals should be aware of the importance of residents' rights, and specific residents' rights. This course will provide insight into the importance of residents' rights, while highlighting the specific rights of residents. Additionally, this course will review recommendations that may be used to uphold residents' rights, and optimize resident care.

Section 1: Resident Abuse

A 72-year-old male resident of a health care facility asks a health care professional questions regarding his rights as a resident. The health care professional begins to answer the resident's questions, and review his individual rights as a resident of a health care facility. As the health care professional reviews the resident's rights, the resident asks the health care professional the following question; why are residents' rights important? The health care professional pauses and considers the resident's question.

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As previously mentioned, residents of health care facilities have specific rights protected by law. The question is, why are residents' rights important? Residents' rights are important because they help ensure residents of health care facilities receive safe and effective health care, and they help prevent resident abuse. With that in mind, this section of the course will provide insight into resident abuse. The information found within this section of the course was derived from materials provided by the Centers for Disease Control and Prevention (CDC) and the National Institute on Aging unless, otherwise, specified (Centers for Disease Control and Prevention [CDC], 2021; National Institute on Aging, 2020).

What is resident abuse?

Resident abuse may refer to an intentional act or failure to act that causes or creates a risk of harm to a resident of a health care facility.

Health care professionals should note that resident abuse may refer to a single act, a repeated act, and/or a lack of appropriate action.

What are the major types of resident abuse?

The major types of resident abuse include: physical abuse, verbal/emotional abuse, psychological abuse, sexual abuse, financial exploitation/abuse, health care financial fraud, confinement, neglect, and elder abandonment. Specific information on the aforementioned types of resident abuse may be found below.

- **Physical abuse -** physical abuse may refer to the intentional use of physical force against an individual that leads to illness, pain, injury, functional impairment, distress, and/or death. Health care professionals should note the following examples of the types of physical force/abuse that may be used against a resident: hitting, punching, kicking, pushing, pinching, slapping, biting, and burning. Health care professionals should also note that physical abuse against residents may include the inappropriate use of drugs, as well as physical punishment of any kind (e.g., pinching or slapping residents because they dropped food or spilled a liquid).

- **Verbal/emotional abuse -** verbal/emotional abuse may refer to verbal and/or nonverbal behaviors that inflict anguish, mental pain, fear, or distress on an individual. Examples of verbal/emotional abuse include the following: yelling, swearing, humiliating an individual, repeatedly threatening an individual, making insulting or disrespectful comments towards an individual, and habitual blaming and/or scapegoating (note: scapegoating may refer to the act of assigning responsibility to an individual for wrong doing, who is not necessary responsible for said wrong doing, so the individual assumes fault and any related suffering). Health care professionals should note that verbal/emotional abuse may be intentionally used by an individual to control and/or manipulate a resident.

- **Psychological abuse -** psychological abuse may refer to a type of coercive or threatening behavior that establishes a power differential between two or more individuals. Examples of psychological abuse may include treating a resident like a child and preventing a resident from interacting with family members and/or friends. Health care professionals should note that psychological abuse may also be intentionally used by an individual to control and/or manipulate a resident.

- **Sexual abuse -** sexual abuse may refer to any forced or unwanted sexual interaction with an individual (i.e., a sexual interaction with an individual that occurs without the individual's consent). Examples of sexual abuse include: unwanted sexual contact (e.g., touching; foundling; grabbing), unwanted sexual

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intercourse, rape, coerced nudity (e.g., one individual persuades or threatens another individual to get nude in front of him or her), forcing an individual to look at pornographic materials, photographing an individual while he or she is nude and/or partially nude, and sexual harassment (note: the term sexual harassment may refer to any act characterized by unwelcomed and/or inappropriate sexual remarks/behavior). Health care professionals should note that sexual abuse may be one of the most underreported types of resident abuse.

- **Financial exploitation/abuse -** financial exploitation/abuse may refer to the illegal, unauthorized, or improper use of an individual's money, benefits, belongings, property, and/or assets. Examples of financial exploitation include: misuse of an individual's funds, denying an individual access to his or her own funds, taking money under false pretenses, using an individual's credit card for personal use without consent, embezzlement, fraud, identity theft, forgery, forced property transfers, as well as the improper use of a power of attorney (note: the term power of attorney may refer to any written, legally binding authorization and/or authority that grants powers to an individual to act on another individual's behalf). Health care professionals should note that financial exploitation/abuse may be inflicted on a resident by a member of his or her family as well as friends, personal acquaintances, and outside sources such as telephone and internet scams.
- **Health care financial fraud -** health care financial fraud may refer to any unethical action, involving finances/money, towards an individual receiving health care by a health care professional (e.g., doctor; nurse; physical therapist). Examples of health care financial fraud include the following: charging for health care services that were not performed, overcharging for health care services, and patient/ resident coercion. Health care professionals should note that health care financial fraud may occur in any health care facility.
- **Confinement -** confinement may refer to any action that restrains or confines an individual for reasons unrelated to health care. Examples of confinement may include the following: locking an individual in his or her residence so he or she cannot get out, locking an individual in his or her bedroom, locking an individual in a closet, and preventing an individual from leaving his or her bed or a specific area of his or her residence. Health care professionals should note that confinement may be used by individuals to prevent residents from reporting incidents of resident abuse.

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- **Neglect -** neglect may refer to a failure to meet an individual's basic needs. Examples of neglect include the following: a failure to provide a resident with food and/or water, a failure to provide a resident with shelter, a failure to provide a resident with appropriate clothing, a failure to provide a resident with the means to maintain adequate hygiene, and a failure to provide a resident with required medications and/or health care services. Health care professionals should note the following: residents may suffer from self-neglect; self-neglect may refer to a failure to meet one's own basic needs (i.e., an individual is no longer able to carry out basic tasks such as feeding themselves and/or maintaining adequate hygiene); self-neglect may include: an inability to feed one's self, compulsive hoarding, self-harm, and substance abuse.

- **Elder abandonment -** elder abandonment may refer to the act of intentionally deserting an older adult that is dependent on others for care and/or incapable of self-care (note: the term older adult may refer to an individual 65 years or older). Examples of elder abandonment include the following: a family member leaves an older adult at a health care facility without notifying the health care facility of the older adult's arrival or returning to pick up the older adult; a family member leaves an older adult with another individual without making arrangements for the older adult's care with the individual; someone caring for an older adult leaves his or her duties without notification or a follow-up. Health care professionals should note that elder abandonment can occur at any point in an older adult's care.

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What are the signs of resident abuse?

The signs of resident abuse can depend on the type of resident abuse. Specific information regarding the potential signs of each type of resident abuse may be found below:

- **Physical abuse -** the potential signs of physical abuse may include the following: bruises, hand marks, grip marks, sprains, dislocated joints, broken bones, burns, and missing teeth. Health care professionals should note that the physical injuries sustained from physical abuse may be self-treated by those victimized by physical abuse.

- **Verbal/emotional abuse -** the potential signs of verbal/emotional abuse may include the following: unexplained stress, unexplained fear, unexplained

suspicions towards others or one specific individual, evasive behavior, unresponsive behavior, memory gaps, and sleep disturbance. Health care professionals should note that the potential signs of verbal/emotional abuse may be similar to those of psychological abuse.

- **Psychological abuse -** the potential signs of psychological abuse may include the following: unexplained or uncharacteristic changes in behavior, a lack of interest in socializing with others, isolating behavior, and agitation. Health care professionals should note that the potential signs of psychological abuse may be similar to those of verbal/emotional abuse.

- **Sexual abuse -** the potential signs of sexual abuse may include the following: unexplained bruising on the legs or thighs, unexplained bruising around the genitals, bite marks on the body and/or around the genitals, bleeding from the genitals and/or anus, ripped clothes and/or undergarments, vaginal infections, and the signs/symptoms of newly acquired sexually transmitted diseases (STDs). Health care professionals should note that victims of sexual abuse may be reluctant to report or talk about any kind of sexual abuse.

- **Financial exploitation/abuse -** the potential signs of financial exploitation/abuse may include the following: confusion regarding money, benefits, belongings, property, and/or assets; unexplained loss of money, benefits, belongings, property, and/or assets; unexplained withdrawals from bank accounts; and unexplained signatures on checks. Health care professionals should note that the potential signs of financial exploitation/abuse may also be consistent with those of identity theft (e.g., unexplained bills).

- **Health care financial fraud -** the potential signs of health care financial fraud may include the following: unexplained charges on health care bills, unexplained disappearance of medications, unexplained disappearance of health care supplies, unexplained harm when in the presence of a health care professional, and untreated conditions, diseases, and/or illnesses. Health care professionals should note that victims of health care financial fraud may ask specific, potentially odd, questions or make specific, potentially odd, statements about their health, health care therapy, and/or about a specific health care professional. Health care professionals should consider documenting and investigating any resident statements or claims that may indicate the presence of health care financial fraud.

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- **Confinement -** the potential signs of confinement may include the following: a family member or friend reports that he or she has not seen or heard from the resident in question, bruises that appear to be from restraints or confinements, and rope burns on the wrists and/or body. Health care professionals should note that it may be difficult to observe signs of confinement because the resident in question may be out of sight and/or confined.
- **Neglect -** the potential signs of neglect may include the following: the resident in question may appear to be malnourished; the resident in question may appear to be dehydrated; the resident in question may appear to be disheveled and/or wearing dirty clothing; poor hygiene; a lack of required health care aids (e.g., eye glasses; hearing aids; canes; walkers); and the presence of untreated wounds. Health care professionals should note that the potential signs of neglect may be related to self-neglect.
- **Elder abandonment -** the potential signs of elder abandonment may include the following: the older adult in question may be confused about where he or she is, the older adult in question may be confused about how he or she arrived at a health care facility, and the older adult in question may have been left alone in his or her residence for an indeterminable amount of time. Health care professionals should note that a victim of elder abandonment may simply just appear at a health care facility alone and without any idea or clue as to why he or she is there.

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How may residents victimized by resident abuse appear/present?

Residents victimized by resident abuse may appear/present in a variety of different states. They may appear malnourished, dehydrated, stressed, confused, agitated, fearful, suspicious of others, nonresponsive, and/or evasive. Additionally, residents potentially victimized by resident abuse may present/appear with the physical signs of resident abuse such as: bruises, hand marks, grip marks, sprains, dislocated joints, broken bones, missing teeth, rope burns, and/or untreated wounds. Also, as previously mentioned, a potential victim of resident abuse may simply just appear at a health care facility alone and without any idea or clue as to why he or she is there. Furthermore, residents potentially victimized by resident abuse may display body language indicating that they were abused (e.g., slouching; excessive flinching; unable to maintain eye contact).

In addition to their appearance, residents potently victimized by resident abuse may use wording to describe or articulate their state. Examples of wording that may be used by residents, potentially victimized by resident abuse, to describe or articulate their state may include the statements found below:

- I was hit.
- I was punched.
- I was kicked.
- I am being yelled at.
- I am cursed at all the time.
- I live in fear.
- I am being touched.
- I was fondled.
- I had relations with my caregiver.
- My caregiver and I are having sex.
- All of my money is gone.
- I am not sure what happened to all of my money.
- My caregiver is trying to get me to sign over my house.
- My medications are gone.
- I am not receiving my medications.
- I was tied up.
- I was locked in my bedroom for hours.
- I am hungry all of the time.
- I am not being fed or given drinks.
- I have not washed up in days.
- I am being left alone.

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Health care professionals should note the following: when attempting to distinguish specific wording regarding resident abuse, health care professionals should keep in mind that they may hear or encounter many different versions or variations of the previously highlighted language; additionally, health care professionals should focus their attention on any resident's verbiage which may indicate signs of resident abuse.

What issues or concerns should health care professionals pay particular attention to when attempting to identify residents potentially victimized by resident abuse?

Residents potentially victimized by resident abuse may suffer from dementia. Dementia may refer to a cluster of symptoms centered around an inability to remember, think clearly, and/or make decisions. Health care professionals should work to identify residents suffering from dementia because residents suffering from dementia may be more susceptible to resident abuse. Health care professionals should note the following symptoms of dementia, which include problems with: memory, attention, communication, reasoning, judgment, and/or problem solving. Health care professionals should also note the following signs of dementia: getting lost in a familiar area, forgetting the names of close family and friends, and not being able to complete tasks independently. Additionally, health care professionals should note that dementia is not a normal part of aging.

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Due to the complex effects of resident abuse, those victimized by resident abuse may experience suicidal ideation. Suicidal ideation may refer to thoughts of suicide and/or thoughts of planning suicide. Health care professionals should be very aware that residents victimized by resident abuse may be suicidal or may have attempted suicide (suicide may refer to a death caused by self-directed injurious behavior with any intent to die as a result of the behavior; a suicide attempt may refer to a non-fatal self-directed and potentially injurious behavior with any intent to die as a result of the behavior). Health care professionals should make every effort to identify the potential for suicide and prevent resident suicide, when applicable.

What are the complications typically associated with resident abuse?

- **Physical injuries** - one of the first complications that may come to mind when considering resident abuse is the possibility for physical injuries. As previously mentioned, the physical injuries that may result from resident abuse include:

bruises, hand marks, grip marks, sprains, dislocated joints, broken bones, burns, restraint burns, rope burns, and missing teeth. Health care professionals should note the following: health care professionals should treat and document any physical injuries that potentially resulted from resident abuse.

- **Pain -** as previously mentioned, due to physical injuries, residents victimized by resident abuse may experience pain. Pain may refer to an unpleasant sensory and emotional experience arising from actual or potential tissue damage. Health care professionals should work to evaluate/assess and treat any physical pain that potentially resulted from resident abuse. Health care professionals should note the following: health care professionals may evaluate/assess a resident's pain and related discomfort by using pain assessment tools, such as a numerical pain intensity scale.

- **Pressure injuries -** a resident victimized by resident abuse, specifically neglect, may experience a pressure injury. A pressure injury, also referred to as a pressure ulcer or bedsore, may refer to localized damage to the skin and/or underlying soft tissue, usually over a bony prominence. Pressure injuries typically result from intense and/or prolonged pressure. A pressure injury can present as intact skin or an open ulcer. Pressure injuries can be painful to residents, and typically affect high-risk resident populations such as older adults and older adults victimized by resident abuse. When evaluating the presence of pressure injuries, health care professionals should attempt to identify the stage or type of pressure injury. Specific information regarding the different stages/types of pressure injuries may be found below. The information found below was derived from materials provided by the Joint Commission (Joint Commission, 2022).

    - **Stage 1 pressure injury -** Stage 1 pressure injuries are characterized by intact skin with a localized area of non-blanchable erythema (i.e., Stage 1 pressure injuries are characterized by a superficial reddening of the skin that, when pressed, does not turn white).

    - **Stage 2 pressure injury -** Stage 2 pressure injuries are characterized by partial-thickness skin loss with exposed dermis; a Stage 2 pressure injury wound bed is typically viable, pink or red, moist, and may present as an intact or ruptured serum-filled blister; adipose (fat) is not visible and deeper tissues are not visible; granulation tissue, slough and eschar are not present. Slough may refer to a layer or mass of necrotic or dead tissue. Eschar may refer to dead tissue that sheds or falls from the skin.

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- **Stage 3 pressure injury -** Stage 3 pressure injuries are characterized by full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (note: epibole may refer to rolled wound edges) are often present; slough and/or eschar may be visible; the depth of tissue damage varies by anatomical locations; undermining and tunneling may occur; fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed.

- **Stage 4 pressure injury -** Stage 4 pressure injuries are characterized by full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage, or bone in the ulcer; slough and/or eschar may be visible; epibole, undermining and/or tunneling often occur; depth varies by anatomical location.

- **Unstageable pressure injury -** unstageable pressure injuries are characterized by full-thickness skin and tissue loss in which the extent of the tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar; if slough or eschar is removed, a Stage 3 or Stage 4 pressure injury may be revealed. Health care professionals should note the following regarding an unstageable pressure injury: stable eschar on an ischemic limb or the heel(s) should not be removed; stable eschar may refer to eschar/dead tissue that is dry, adherent, and intact without erythema or fluctuance.

- **Deep tissue pressure injury -** deep tissue pressure injuries are characterized by intact or non-intact skin with localized area or persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood-filled blister; pain and temperature changes often preceded skin color changes; discoloration may appear differently in darkly pigmented skin. Health care professionals should note the following regarding a deep tissue pressure injury: deep tissue pressure injuries typically result from intense and/or prolonged pressure and shear forces at the bone-muscle interface; the wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss; if necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle, or other underlying structures are visible, this indicates a full-thickness pressure injury (unstageable, Stage 3 or Stage 4).

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- **Medical device-related pressure injury -** medical device-related pressure injuries result from the use of devices designed and applied for diagnostic or therapeutic purposes. Health care professionals should note the following: a medical device-related pressure injury generally conforms to the pattern or shape of the device; the injury should be staged according to the aforementioned stages.
- **Mucosal membrane pressure injury -** a mucosal membrane pressure injury may be found on mucous membranes with a history of a medical device used at the location of the injury. Health care professionals should note the following: due to the anatomy of the tissue, typically, mucosal membrane pressure injuries cannot be staged.

- **Malnutrition and dehydration -** as previously mentioned, residents victimized by resident abuse may suffer from malnutrition and dehydration. Malnutrition may refer to a condition that occurs when the body doesn't get enough nutrients. Dehydration may refer to a state or condition that occurs when the body doesn't have enough water and other fluids to carry out its normal functions that maintain life. Health care professionals should note the following signs/symptoms of malnutrition: fatigue, dizziness, poor concentration, and weight loss. Health care professionals should also note the following signs/symptoms of dehydration: dizziness, dry skin, yellow and/or dark urine, and decreased urine production.
- **Depression -** due to the effects of resident abuse, residents victimized by resident abuse may experience depression. A depressive disorder may refer to a mood disorder characterized by a persistent depressed mood and/or anhedonia, which ultimately causes significant interference in daily life (note: anhedonia may refer to a loss of interest in previously enjoyable activities). Health care professionals should note the following symptoms of a depression disorder: depressed mood, anhedonia, appetite changes, weight changes, sleep difficulties, psychomotor agitation or retardation, fatigue or loss of energy, diminished ability to think or concentrate, feelings of worthlessness or excessive guilt, and suicidality.
- **Anxiety -** in addition to depression, residents victimized by resident abuse may experience anxiety. An anxiety disorder may refer to a mental health disorder characterized by prolonged periods of persistent, excessive worry about a number of events or activities, which cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (note: excessive worry may refer to worrying when there is no specific reason/threat

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present or in a manner that is disproportionate to the actual risk of an event, activity, and/or situation). Health care professionals should note the following symptoms of an anxiety disorder: excessive anxiety, excessive worry, restlessness, persistent feelings of being keyed up or on edge, easily fatigued, difficulty concentrating, mind feeling blank at times (i.e., mind going blank), irritability, and muscle tension.

- **Post-traumatic stress disorder (PTSD) -** research suggests that abuse and/or trauma related to abuse, of any kind, may be associated with post-traumatic stress disorder (PTSD). Specific information regarding PTSD may be found below. The information found below was derived from materials provided by the National Institute of Mental Health (National Institute of Mental Health, 2019).
    - PTSD may refer to a psychiatric disorder characterized by intense physical and emotional responses to thoughts and reminders of a traumatic event(s) (e.g., the death of a loved one) (note: the term traumatic event may refer to an event, or series of events, that cause a moderate to severe stress reaction).
    - The risk factors associated with PTSD include the following: experienced a traumatic event; witnessed a traumatic event; a close family member or friend experiences a traumatic event; social isolation after a traumatic event; the sudden, unexpected death of a loved one; history of mental illness; history of substance abuse; stress; prolonged periods of unrelenting stress; consistent feelings of horror or extreme fear; consistent feelings of helplessness.
    - PTSD may lead to re-experiencing symptoms, avoidance symptoms, arousal and reactivity symptoms, and cognition and mood symptoms.
    - Re-experiencing symptoms - re-experiencing symptoms may refer to symptoms that force or trigger a person to re-experience a traumatic event. Re-experiencing symptoms include the following: nightmares; fearful thoughts; guilty thoughts; flashbacks (note: the term flashback may refer to the re-emergence of memories associated with a traumatic event that manifest a collection of overwhelming sensations, such as emotionally disturbing images and sounds).
    - Avoidance symptoms - avoidance symptoms may refer to symptoms that force an individual to alter his or her daily routines. Avoidance symptoms

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include the following: avoids thoughts related to a traumatic event; avoids feelings related to a traumatic event; avoids individuals related to a traumatic event; avoids places, events, or objects related to a traumatic event.

- Arousal and reactivity symptoms - arousal and reactivity symptoms may refer to symptoms that cause long-term feelings of rage, anger, and stress. Arousal and reactivity symptoms include the following: rage; anger; anger outbursts; feeling stressed; feeling tense; feeling on edge; easily startled; problems sleeping.
- Cognition and mood symptoms - cognition and mood symptoms may refer to symptoms that impact an individual's ability to think, reason, apply logic, and perceive reality that are not related to injury or substance use. Cognition and mood symptoms include the following: forgetfulness; inability to remember important aspects of a traumatic event; negative and distorted thoughts about oneself and others; negative and distorted thoughts about feelings and emotions; negative and distorted thoughts about reality; anhedonia.
- PTSD is typically diagnosed by a health care professional using criteria outlined in the American Psychiatric Association's Diagnostic and Statistical Manual, Fifth edition (DSM-5).

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- **Sexually transmitted diseases (STDs) -** as previously eluded to, resident abuse, specifically sexual abuse, may lead to the transmission of STDs. The term sexually transmitted disease (STD) may refer to an infection transmitted through sexual contact that may be caused by bacteria, viruses, or parasites. Health care professionals should note the following STDs: gonorrhea, syphilis, chlamydia, human papillomavirus, genital herpes, human immunodeficiency virus(HIV), and trichomoniasis.
- **Financial hardship -** residents victimized by resident abuse, specifically financial exploitation/abuse and health care financial fraud, may suffer financial hardship. Health care professionals should note that residents victimized by resident abuse may be stripped of their money, benefits, belongings, property, and/or assets and, ultimately, left with nothing. Health care professionals should also note that residents victimized by financial exploitation/abuse and health care financial fraud may require financial aid.

- **Death -** finally, health care professionals should note that the effects of resident abuse may lead to the untimely death of a resident, especially if a resident is victimized by physical abuse, neglect, and/or elder abandonment.

Section 1 Summary

Resident abuse may refer to an intentional act or failure to act that causes or creates a risk of harm to a resident of a health care facility. The major types of resident abuse include: physical abuse, verbal/emotional abuse, psychological abuse, sexual abuse, financial exploitation/abuse, health care financial fraud, confinement, neglect, and elder abandonment. The signs of resident abuse can depend on the type of resident abuse. Complications typically associated with resident abuse include: physical injuries, pain, pressure injuries, malnutrition and dehydration, depression, anxiety, PTSD, STDs, financial hardship, and death. Lastly, health care professionals should work to identify residents potentially victimized by resident abuse to ensure they receive the care they need.

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Section 1 Key Concepts

- Residents of health care facilities have specific rights protected by law.
- Resident rights are important because they help ensure residents of health care facilities receive safe and effective health care, and they help prevent resident abuse.
- Resident abuse may refer to a single act, a repeated act, and/or a lack of appropriate action.

Section 1 Key Terms

Resident abuse - an intentional act or failure to act that causes or creates a risk of harm to a resident of a health care facility

Physical abuse - the intentional use of physical force against an individual that leads to illness, pain, injury, functional impairment, distress, and/or death

Verbal/emotional abuse - verbal and/or nonverbal behaviors that inflict anguish, mental pain, fear, or distress on an individual

Scapegoating - the act of assigning responsibility to an individual for wrong doing, who is not necessary responsible for said wrong doing, so the individual assumes fault and any related suffering

Psychological abuse - a type of coercive or threatening behavior that establishes a power differential between two or more individuals

Sexual abuse - any forced or unwanted sexual interaction with an individual

Sexual harassment - any act characterized by unwelcomed and/or inappropriate sexual remarks/behavior

Financial exploitation/abuse - the illegal, unauthorized, or improper use of an individual's money, benefits, belongings, property, and/or assets

Health care financial fraud - any unethical action, involving finances/money, towards an individual receiving health care by a health care professional

Confinement - any action that restrains of confines an individual for reasons unrelated to health care

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Neglect - a failure to meet an individual's basic needs

Self-neglect - a failure to meet one's one basic needs

Elder abandonment - the act of intentionally deserting an older adult that is dependent on others for care and/or incapable of self-care

Older adult - an individual 65 years or older

Dementia - a cluster of symptoms centered around an inability to remember, think clearly, and/or make decisions

Suicidal ideation - thoughts of suicide and/or thoughts of planning suicide

Suicide - a death caused by self-directed injurious behavior with any intent to die as a result of the behavior

Suicide attempt - a non-fatal self-directed and potentially injurious behavior with any intent to die as a result of the behavior

Pain - an unpleasant sensory and emotional experience arising from actual or potential tissue damage

Pressure injury (also referred to as a pressure ulcer or bedsore) - localized damage to the skin and/or underlying soft tissue, usually over a bony prominence

Slough - a layer or mass of necrotic or dead tissue

Eschar - dead tissue that sheds or falls from the skin

Epibole - rolled wound edges

Stable eschar - eschar/dead tissue that is dry, adherent, and intact without erythema or fluctuance

Malnutrition - a condition that occurs when the body doesn't get enough nutrients

Dehydration - a state or condition that occurs when the body doesn't have enough water and other fluids to carry out its normal functions that maintain life

Depressive disorder - a mood disorder characterized by a persistent depressed mood and/or anhedonia, which ultimately causes significant interference in daily life

Anhedonia - a loss of interest in previously enjoyable activities

Anxiety disorder - a mental health disorder characterized by prolonged periods of persistent, excessive worry about a number of events or activities, which cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

Excessive worry (in the context of an anxiety disorder) - worrying when there is no specific reason/threat present or in a manner that is disproportionate to the actual risk of an event, activity, and/or situation

Post-traumatic stress disorder (PTSD) - a psychiatric disorder characterized by intense physical and emotional responses to thoughts and reminders of a traumatic event(s)

Traumatic event - an event, or series of events, that causes a moderate to severe stress reaction

Re-experiencing symptoms - symptoms that force or trigger a person to re-experience a traumatic event

Flashback - the re-emergence of memories associated with a traumatic event that manifest a collection of overwhelming sensations, such as emotionally disturbing images and sounds

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Avoidance symptoms - symptoms that force an individual to alter his or her daily routines

Arousal and reactivity symptoms - symptoms that cause long-term feelings of rage, anger, and stress

Cognition and mood symptoms - symptoms that impact an individual's ability to think, reason, apply logic, and perceive reality that are not related to injury or substance use

Sexually transmitted disease (STD) - an infection transmitted through sexual contact that may be caused by bacteria, viruses, or parasites

Section 1 Personal Reflection Question

How can health care professionals effectively identify individuals potentially victimized by resident abuse?

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Section 2: Residents' Rights Recommendations

Resident abuse can negatively impact a resident's health, overall well-being, and quality of life. Therefore, health care professionals should work to uphold residents' rights, and prevent resident abuse. Health care professionals can work to uphold residents' rights, and prevent resident abuse by following residents' rights recommendations. Specific residents' rights recommendations may be found below. The information found in this section of the course was derived from materials provided by the CDC unless, otherwise, specified (CDC, 2020).

Residents' Rights Recommendations

- **Adhere to the ethic principles of health care -** first and foremost, health care professionals should adhere to the following four major ethic principles of health care to help uphold residents' rights, and prevent resident abuse: patient autonomy, beneficence, nonmaleficence, and justice. Specific information regarding the four major ethic principles of health care may be found below.
    - Patient autonomy may refer to a patient's right to make decisions regarding his or her own personal health care, without the direct influence of a health care professional. Health care professionals may uphold patient

autonomy by allowing patients to remain independent when making decisions about their health care.

  - Beneficence, as it relates to health care, may refer to the obligation of the health care professional to act in the best interest of the patient. Health care professionals may uphold the ethic principle of beneficence by simply doing what is best for a patient's health.
  - Nonmaleficence, as it relates to health care, refers to the obligation of the health care professional to act in a manner that does not cause harm to the individual patient; do no harm (note: although beneficence and nonmaleficence are related, they are two separate and distinct ethic principles of health care). Health care professionals may also uphold the ethic principle of nonmaleficence by simply acting in a manner that does not intentionally harm a patient.
  - Justice, as it relates to health care, refers to the fair and equitable distribution of health care resources to patients. Health care professionals can uphold the ethic principle of justice by administering health care in an unbiased manner.

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- **Pursue education regarding resident abuse -** health care professionals should pursue education regarding resident abuse so they may possess the necessary insight to discuss, identify, and, ultimately, effectively work to prevent resident abuse. Health care professionals should note the following: health care information is always being updated; health care professionals should pursue opportunities to further their education; remaining up to date on relevant health care topics can help health care professionals in their daily practice and can further their understanding of how to provide safe and effective health care to patients in need.
- **Provide counseling and education to residents about resident abuse and how to report resident abuse -** to build on the previous recommendation, health care professionals should provide counseling and education to residents about resident abuse and how to report resident abuse, so they may be able to effectively acknowledge and identify resident abuse and adequately report it to family members, friends, health care professionals, and organizations such as the National Adult Protective Services Association. Health care professionals should note that the National Adult Protective Services Association is an organization

that works to provide services (e.g., protection against financial exploitation/ abuse) to individuals victimized by abuse.

- **Work reduction and/or avoid stress, which is often associated with caring for residents -** stress is often indicated as a possible contributor to resident abuse (note: stress may refer to a factor that causes emotional, physical, or psychological tension). Thus, health care professionals should work to reduce and/or avoid stress. Health care professionals should note the following methods to reduce stress: exercise, yoga, and meditation.
- **Work to reduce and/or avoid burn-out, which is often associated with health care -** to build on the previous recommendation, health care professionals should work to reduce and/or avoid burn-out (note: stress may lead to burn-out). Burn-out may refer to a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed (World Health Organization [WHO], 2019). Health care professionals should note that burn-out is characterized by the following three dimensions: feelings of energy depletion or exhaustion; increased mental distance from one's job, or feelings of negativism or cynicism related to one's job; and reduced professional efficacy (WHO, 2019). Health care professionals should also note that the use of the collaborative staffing model may serve as a method to help reduce burn-out in health care settings. Specific information regarding the collaborative staffing model may be found below. The information found below was derived from materials provided by the American Association of Critical-Care Nurses (American Association of Critical-Care Nurses, 2018).
    - The collaborative staffing model may refer to an employee staffing model that encourages and allows health care managers and health care professionals to work together to create schedules and/or fill required open shifts across a health care organization.
    - The collaborative staffing model helps remove the traditional hierarchical structure of a health care organization that may not be relevant in the modern era of health care.
    - In order for the collaborative staffing model to be effective, health care organizations must have a means for health care professionals to view and fill schedules/open shifts.

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- In order for the collaborative staffing model to be effective, health care organizations must have a means for health care professionals to communicate information regarding schedules/open shifts.
- In order for the collaborative staffing model to be effective, health care organizations must establish channels for effective horizontal communication (note: horizontal communication may refer to the flow of communication between individuals and/or departments that are on the same level of a given organization).
- The collaborative staffing model can help reduce some of the scheduling burden for health care managers, while providing them additional time to focus on other vital issues or concerns.
- The collaborative staffing model can help health care organizations fill schedules/open shifts to help meet the demands of the coronavirus disease 2019 (COVID-19) pandemic (note: coronavirus disease 2019 [COVID-19] may refer to a respiratory illness that can spread from person to person, which is caused by a virus known as the severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2]).
- The collaborative staffing model can help foster professional teamwork, which in turn could help health care professionals create professional bonds that may impact employee burn-out, and, subsequently, employee retention.
- The collaborative staffing model can help increase employee satisfaction. Health care professionals should note the following: some of the most cited reasons why health care professionals leave health care organizations are centered around scheduling issues and low employee satisfaction; the collaborative staffing model can help health care organizations address the aforementioned reasons why health care professionals leave health care organizations.

- **Identify and/or assist health care professionals that may be dealing with substance abuse -** due to the stress and burn-out often associated with caring for residents, health care professionals may suffer from substance abuse. Health care professionals should note that health care professional-related substance abuse may act as a catalyst for resident abuse or further resident abuse. Health care professionals should note the following: substance abuse may refer to the

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harmful or hazardous use of a psychoactive substance such as alcohol and illicit drugs. Health care professionals should also note the following signs of alcohol and illicit drug use: slurred speech, an active tremor, shakiness, poor coordination, sweating, nausea, vomiting, aggression, agitation, compulsive behavior, craving, red eyes, dry mouth, drowsiness, involuntary eye movements, dilated pupils, nasal congestion, mouth sores, reduced consciousness, lack of pain sensation, intolerance to loud noise, dizziness, confusion, lack of awareness to surroundings, and needle marks.

- **Health care professionals should be aware of internal channels, within their health care organizations, for reporting resident abuse -** health care facilities may have specific internal channels for reporting resident abuse. Health care professionals should be aware of such channels to effectively report potential resident abuse. If no such channels exist, health care professionals should consider developing internal channels, within their health care organizations, for reporting resident abuse. Health care professionals should note that they may find information regarding resident abuse and the reporting of resident abuse within their specific health care organizations' policies and procedures.

- **Report potential resident abuse -** health care professionals should report any potential resident abuse. Reporting potential resident abuse can prevent resident abuse, and ultimately, stop it from occurring. Health care professionals should note that they may report abuse, internally, within their health care organizations or to outside organizations, such as the National Adult Protective Services Association.

- **Apply fall precautions to residents -** residents, especially, older adult residents may be susceptible to falls (note: the term fall may refer to an event which results in an individual coming to rest on the ground or a lower level). Placing a resident in a situation where he or she is susceptible to a fall may be viewed as resident abuse (e.g., neglect). Thus, health care professionals should consider fall precautions when caring for residents. Health care professionals should note that fall precautions constitute the basics of patient safety and should be applied in all health care facilities to all patients. Specific fall precautions may be found below.

  Fall Precautions

  - Familiarize the resident with the environment
  - Have the resident demonstrate call light use, when applicable

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- Maintain call light within reach
- Keep residents' personal possessions within safe reach of the individual resident
- Have sturdy handrails in residents' rooms, bathrooms, and hallways
- Place the resident's bed in a low position when a resident is resting in bed; raise the resident's bed to a comfortable height when the resident is transferring out of bed, when applicable
- Keep residents' bed brakes locked
- Keep wheelchair wheel locks in the locked position when stationary, when applicable
- Keep nonslip, comfortable, well-fitting footwear on the resident
- Use night lights or supplemental lighting
- Keep floor surfaces clean and dry
- Clean up all spills promptly
- Keep resident care areas uncluttered
- Follow safe patient handling practices

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- **Screen residents to determine if they are at risk for falls -** to build on the previous recommendation, health care professionals should screen residents to determine if they are at risk for falls. Health care professionals can effectively screen residents to determine if they are at risk for falls by using the Stay Independent 12-question tool (note: the Stay Independent 12-question tool may be used to screen older adult residents). Specific information regarding the Stay Independent 12-question tool may be found below.
    - **Stay Independent 12-question tool -** the Stay Independent 12-question tool can help health care professionals determine if an older adult is at risk for falls. The Stay Independent 12-question tool includes the following questions, which older adults should honestly answer and health care professionals should appropriately score: I have fallen in the past year; I use or have been advised to use a cane or walker to get around safely; sometimes I feel unsteady when I am walking; I steady myself by holding

onto furniture when walking at home; I am worried about falling; I need to push with my hands to stand up from a chair; I have some trouble stepping up onto a curb; I often have to rush to the toilet; I have lost some feeling in my feet; I take medicine that sometimes makes me feel light-headed or more tired than usual; I take medicine to help me sleep or improve my mood; I often feel sad or depressed. Health care professionals should note the following: each "yes" answer to questions 1 and 2 should receive 2 points; each "yes" answer to questions 3 - 12 should receive 1 point; each "no" answer to any of the 12 questions should receive zero points; health care professionals should add up the total number of points once the older adult has answered all 12 questions to the best of his or her ability. Health care professionals should also note the following: if an older adult's total score is 4 points or more, he or she may be at risk for falling.

- **Assess residents' fall risk** - once health care professionals screen a resident and determine if the resident is at risk for falls, then health care professionals should assess the resident's fall risk, when applicable. Health care professionals can effectively assess residents' fall risk by using the following fall risk assessment tools: Timed Up and Go, 30 Second Chair Stand, and 4-Stage Balance Test. Specific information regarding the aforementioned fall risk assessment tools may be found below (note: the aforementioned fall risk assessment tools may be used to screen older adult residents).

  - **Timed Up and Go** - the Timed Up and Go fall risk assessment tool assesses an individual's mobility. A health care professional will require a stopwatch to effectively conduct the Timed Up and Go fall risk assessment. During a Timed Up and Go fall risk assessment, older adults should wear their typical footwear and use walking aids (e.g., chain), if applicable. To begin the Timed Up and Go fall risk assessment, health care professionals should instruct older adult residents to sit back in a standard arm chair. Health care professional should then highlight or identify a line 10 feet away from the resident on the floor in front of the resident. Health care professionals should then provide older adult residents with the following instructions: when "I" say "go", stand up from the chair, walk to the line on the floor at your normal pace, turn, walk back to the chair at your normal pace, and sit down again. Health care professionals should start timing the older adult resident on the word "go." Health care professionals should also stop timing the older adult resident after the resident sits back down, and

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record the time. Health care professionals should note the following: an older adult who takes ≥ 12 seconds to complete the Timed Up and Go fall risk assessment is at risk for falling. Health care professionals should also note the following: during a Timed Up and Go fall risk assessment, the health care professional should stay by an older adult resident for safety reasons.

- **30 Second Chair Stand -** the 30 Second Chair Stand fall risk assessment tool assesses an individual's leg strength and endurance. A health care professional will require a chair with a straight back and without arm rests as well as a stopwatch to effectively conduct the 30 Second Chair Stand fall risk assessment. To begin the 30 Second Chair Stand fall risk assessment, health care professionals should provide older adult residents with the following instructions: sit in the middle of the chair; place your hands on the opposite shoulder crossed, at the wrists; keep your feet flat on the floor; keep your back straight, and keep your arms against your chest; when "I" say "go," rise to a full standing position, then sit back down again; repeat the aforementioned action for 30 seconds. Health care professionals should start timing the older adult on the word "go;" count the number of times the older adult resident comes to a full standing position in 30 seconds; and record the number of times the older adult resident stands in 30 seconds. Health care professionals should note the following: if the older adult resident must use his or her arms to stand, stop the test, health care professionals should record "0" for the number and score; if the older adult resident is over halfway to a standing position when 30 seconds have elapsed, health care professionals should count it as a stand. Health care professionals should also note the following 30 Second Chair Stand below average scores: for men between the ages of 60 - 64 years a below average score is < 14; for women between the ages of 60 - 64 years a below average score is < 12; for men between the ages of 65 - 69 years a below average score is < 12; for women between the ages of 65 - 69 years a below average score is < 11; for men between the ages of 70 - 74 years a below average score is < 12; for women between the ages of 70 - 74 years a below average score is < 10; for men between the ages of 75 - 79 years a below average score is < 11; for women between the ages of 75 - 79 years a below average score is < 10; for men between the ages of 80 - 84 years a below average score is < 10; for women between the ages of 80 - 84 years a below average score is < 9; for men between the ages of

85 - 89 years a below average score is < 8; for women between the ages of 85 - 89 years a below average score is < 8; for men between the ages of 90 - 94 years a below average score is < 7; for women between the ages of 90 - 94 years a below average score is < 4. Additionally, health care professionals should note the following: a below average 30 Second Chair Stand score indicates the individual is at risk for falls. Furthermore, health care professionals should note the following: during a 30 Second Chair Stand fall risk assessment, the health care professional should stay by an older adult resident for safety reasons.

- **4-Stage Balance Test -** the 4-Stage Balance Test assessment tool assesses an individual's static balance. A health care professional will require a stopwatch to effectively conduct the 4-Stage Balance Test. During a 4-Stage Balance Test, older adult residents should keep their eyes open and should not use walking aids (e.g., canes; walkers), if applicable. To begin the 4-Stage Balance Test, health care professionals should provide older adult residents with the following instructions: "I'm" going to show you four positions; after I show you the positions try to stand in each position for 10 seconds; "you" can hold your arms out, or move your body to help keep your balance, but don't move your feet; for each position "I" will say, "ready, begin;" then, I will start timing; after 10 seconds, "I" will say, "stop;" when "I" say "stop" you may stop holding the position and return to a standing position of rest. Health care professionals should then demonstrate the following four positions to the older adult resident: Position 1 - feet side-by-side; Position 2 - the instep of one foot should be touching the big toe of the other foot; Position 3 - one foot in front of the other with the heel touching the toes; Position 4 - stand on one foot. Once each of the positions is clear to the older adult resident, health care professionals should then stand next to the older adult resident, hold his or her arms, and help the older adult resident assume the correct position. When the resident is steady, the health care professionals should let go, and time how long the older adult patient can maintain the position. Health care professionals should note the following: if the older adult resident can hold a position for 10 seconds without moving his or her feet or needing support, the health care professionals should then move on to the next position; if the older adult resident cannot hold a position for 10 seconds without moving his or her feet or needing support, the health care professional should not move on to the next position and should stop the

test. Health care professionals should also note the following: an older adult resident who cannot hold Position 3 (otherwise referred to as the tandem stand) for at least 10 seconds is at an increased risk of falling. Additionally, health care professionals should note the following: during a 4-Stage Balance Test, health care professionals should remain ready to assist the resident if they should lose their balance.

- **Ensure residents have adequate personal hygiene -** inadequate personal hygiene may be viewed as resident abuse or a sign of resident abuse (e.g., neglect). Thus, health care professionals should ensure residents have adequate personal hygiene. Personal hygiene may refer to a series of practices that sustain the body's cleanliness in order to maintain healthy skin integrity, as well as overall health and well-being (note: adequate personal hygiene can help prevent the spread of diseases among residents) (National Institute on Aging, 2017). Important aspects of adequate personal hygiene include the following: bathing regularly, water use, skin cleansing product use, drying, and mouth care (National Institute on Aging, 2017). Specific information regarding the aforementioned important aspects of adequate personal hygiene may be found below. The information found below was derived from materials provided by the National Institute on Aging (National Institute on Aging, 2017).

    - **Bathing regularly -** bathing regularly can help prevent the spread of infections and diseases among residents. It can also have a positive psychological impact on residents. Bathing regularly can help residents: feel better about themselves, improve upon their self-esteem, improve self-image, feel more relaxed, maintain their dignity, and feel like they have some semblance of control over their health and well-being. With the previous concepts in mind, health care professionals should note the following: before the resident bathing process begins, health care professionals should get bathing necessities (e.g., soap) ready to ease the bathing process; health care professionals should make sure the bathing area is warm and well lit; during the bathing process, health care professionals should never leave a confused resident alone; health care professionals should ensure water temperature is comfortable for the residents; health care professionals should use a hand-held showerhead for safety reason, when applicable; health care professionals should ensure a rubber bath mat, safety bars, and other related safety items are located in the resident bathing area; health care professionals should use a sturdy

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shower chair to support a resident who is unsteady in order to prevent falls; health care professionals should maintain resident bathing education, schedules, and routines.

- **Water use -** effective water use is a fundamental aspect of adequate personal hygiene. Effective water use in personal hygiene occurs when water is used to clean the skin in a manner that does not jeopardize skin integrity and/or lead to or cause further impaired skin integrity. To ensure residents are effectively using water when engaging in personal hygiene, health care professionals should provide residents with the following education points: use warm water when engaging in personal hygiene rather than hot water or extremely hot water to reduce the risk of dehydrating the skin; do not shower for long periods of time to reduce the risk of dehydrating the skin and compromising skin integrity; do not over-clean (e.g., bathing and/or showering to frequently and/or for excessive periods of time) (note: over-cleaning the skin may lead to itching, dryness, and compromised skin integrity).

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- **Skin cleansing product use -** the use of a skin cleansing product is another fundamental aspect of adequate personal hygiene. The term skin cleansing product may refer to any product designed to clean the human body while removing dirt, bacteria, dead skin cells, and/or other substances from the skin. Health care professionals should consider encouraging residents to use emollient-based soap substitutes and/or bath emollients, when applicable. Emollient-based soap substitutes and bath emollients are, typically, designed to remove dirt, bacteria, dead skin cells, and/or other substances from the skin, while avoiding skin barrier breakdown, dryness, and irritation. Health care professionals should note the following: emollient-based soap substitutes and bath emollients are designed to promote skin integrity; it is important for health care professionals to consider resident preferences when selecting or determining which emollient-based soap substitutes and/or bath emollients may be used within health care facilities.

- **Drying -** drying, as it relates to adequate personal hygiene, may refer to the act of removing moisture and/or water from the body/skin after a personal hygiene routine, including water and a skin cleansing product, is completed (e.g., a traditional bath or shower). The act of drying the body and skin is

essential to personal hygiene, skin integrity, and overall health because it can help residents prevent and avoid maceration. Maceration, as it relates to adequate personal hygiene, may refer to skin breakdown resulting from prolonged moisture. Health care professionals should note the following: residents should be encouraged to pat or gently rub their skin when engaging in drying to help prevent related irritation and skin damage; residents should be encouraged to use soft cloths to dry their skin in order to help prevent related irritation and skin damage.

  - **Mouth care -** mouth care may refer to the act of maintaining oral hygiene. Aspects of mouth care may include methods to clean teeth and gums. Health care professionals should note the following: residents should be encouraged to brush their teeth twice a day with fluoride toothpaste, floss regularly, and clean their dentures, when applicable.

- **Ensure residents receive adequate nutrition -** inadequate nutrition may be viewed as resident abuse (e.g., neglect). Thus, health care professionals should ensure residents receive adequate nutrition. Specific information and recommendations regarding adequate nutrition may be found below. The information found below was derived from materials provided by the U.S. Department of Health and Human Services (U.S. Department of Health and Human Services, 2020).

  - Individuals should follow a healthy dietary pattern at every life stage.

  - From 12 months through older adulthood, individuals should follow a healthy dietary pattern across their lifespan to meet nutrient needs, help achieve a healthy body weight, and reduce the risk of chronic disease (note: the term healthy dietary pattern may refer to the combination of foods and beverages that constitutes an individual's complete dietary intake over time; a description of a customary way of eating or a description of a combination of foods recommended for consumption).

  - Individuals should focus on meeting food group needs with nutrient-dense foods and beverages, and stay within calorie limits - nutrient-dense foods provide vitamins, minerals, and other health-promoting components and have no or little added sugars, saturated fat, and sodium. A healthy dietary pattern consists of nutrient-dense forms of foods and beverages across all food groups, in recommended amounts, and within calorie limits (note:

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the term nutrient-dense foods may refer to the foods and beverages that provide vitamins, minerals, and other health-promoting components and have little added sugars, saturated fat, and sodium).

    - Individuals should note that the core elements that make up a healthy dietary pattern include the following: vegetables of all types; fruits, especially whole fruit; grains, at least half of which are whole grain; dairy, including fat-free or low-fat milk, yogurt, and cheese, and/or lactose-free versions and fortified soy beverages and yogurt as alternatives; protein foods, including lean meats, poultry, and eggs; oils, including vegetable oils and oils in food, such as seafood and nuts.

    - Male adults and male older adults should take in approximately 2,000 to 3,000 calories per day, depending on activity level.

    - Female adults and female older adults should take in approximately 1,600 to 2,400 calories per day, depending on activity level.

- **Health care professionals should effectively document the presence of any potential resident abuse -** when working to uphold residents' rights and prevent resident abuse, health care professionals should be sure to effectively document the presence of any potential resident abuse. Effective health care documentation can provide a record of any potential resident abuse, observed signs of the potential resident abuse, and any related complications. Such information may be used to review and determine the presence of resident abuse. Additionally, effective health care documentation, regarding resident abuse, may be used to alert other health care professionals of the possible presence of resident abuse. Health care professionals should note the following: in order for health care documentation to be considered effective, it must function as a viable form of communication, as well as a means to establish a detailed record of health care administration.

- **Health care professionals should foster effective communication when engaging with residents -** effective communication occurs when information and messages are adequately transmitted, received, and understood. Working to foster effective communication when engaging with residents can help health care professionals obtain relevant information that may be used to effectively identify and, ultimately, prevent resident abuse. Health care professionals can foster effective communication when engaging with residents by speaking clearly, actively

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listening to residents when they speak, maintaining eye contact with residents when speaking to them, asking questions, maintaining emotional stability, and by limiting interruptions and distractions. Health care professionals should note the following: when engaging with residents, health care professionals should work to avoid miscommunication; when miscommunication occurs between individuals, intended meaning may be lost; health care professionals can work to avoid miscommunication by removing physical barriers when communicating with other individuals, remaining professional, clarifying points of confusion, and by allowing for a free flow of information between individuals.

- **Inform health care professionals and residents about residents' rights** - lastly, and perhaps most importantly, health care professionals and residents should be informed about residents' rights (i.e., both health care professionals and residents should possess an understanding of residents' rights). Information about residents' rights may be posted in health care facilities or provided directly to health care professionals and residents. Health care professionals should note the following: information regarding residents' rights should be readily accessible to health care professionals and residents.

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Section 2 Summary

Resident abuse can negatively impact a resident's health, overall well-being, and quality of life. Therefore, health care professionals should work to uphold residents' rights, and prevent resident abuse. Finally, residents' rights recommendations should be followed when caring for residents.

Section 2 Key Concepts

- Health care professionals can work to uphold residents' rights, and prevent resident abuse by following residents' rights recommendations.

Section 2 Key Terms

Patient autonomy - a patient's right to make decisions regarding his or her own personal health care, without the direct influence of a health care professional

Beneficence (as it relates to health care) - the obligation of the health care professional to act in the best interest of the patient

Nonmaleficence (as it relates to health care) - the obligation of the health care professional to act in a manner that does not cause harm to the individual patient; do no harm

Justice (as it relates to health care) - the fair and equitable distribution of health care resources to patients

Stress - a factor that causes emotional, physical, or psychological tension

Burn-out - a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed (World Health Organization [WHO], 2019)

Collaborative staffing model - an employee staffing model that encourages and allows health care managers and health care professionals to work together to create schedules and/or fill required open shifts across a health care organization

Horizontal communication - the flow of communication between individuals and/or departments that are on the same level of a given organization

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Coronavirus disease 2019 (COVID-19) - a respiratory illness that can spread from person to person, which is caused by a virus known as the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)

Substance abuse - the harmful or hazardous use of a psychoactive substance such as alcohol and illicit drugs

Fall - an event which results in an individual coming to rest on the ground or a lower level

Healthy dietary pattern - the combination of foods and beverages that constitutes an individual's complete dietary intake over time; a description of a customary way of eating or a description of a combination of foods recommended for consumption (U.S. Department of Health and Human Services, 2020)

Nutrient-dense foods - foods and beverages that provide vitamins, minerals, and other health-promoting components and have little added sugars, saturated fat, and sodium (U.S. Department of Health and Human Services, 2020)

Section 2 Personal Reflection Question

How can health care professionals use the above recommendations to uphold residents' rights, and prevent resident abuse?

Section 3: Title 42 Part 483

Residents' rights are important because they help ensure residents of health care facilities receive safe and effective health care, and they help prevent resident abuse. The question that remains is, what are the specific rights of residents of a health care facility? This section of the course will answer that very question by highlighting residents' rights, as well as related requirements, regulations, and laws included in Title 42 Part 483. The information found within this section of the course was derived from materials provided by the U.S. government unless, otherwise, specified (Code of Federal Regulations, 2022).

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- The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility.
- A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.
- The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.
- The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.
- The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.
- The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights.

- In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated.
- The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the resident representative.
- The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law.
- The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law.
- The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law.
- If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns in the manner required under State law.
- In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law.
- In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decisions outside the representative's authority.
- The resident's wishes and preferences must be considered in the exercise of rights by the representative.

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- To the extent practicable, the resident must be provided with opportunities to participate in the care planning process.
- The resident has the right to be informed of, and participate in, his or her treatment, including: the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition; the right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: the right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care; the right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care; the right to be informed, in advance, of changes to the plan of care; the right to receive the services and/or items included in the plan of care; the right to see the care plan, including the right to sign after significant changes to the plan of care.
- The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must facilitate the inclusion of the resident and/or the resident's representative; include an assessment of the resident's strengths and needs; incorporate the resident's personal and cultural preferences in developing goals of care.
- The resident has the right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care.
- The resident has the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.
- The resident has the right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.
- The resident has the right to self-administer medications if the interdisciplinary team has determined that this practice is clinically appropriate.

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- The resident has the right to choose his or her attending physician (note: physicians must be licensed to practice).
- The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care.
- The facility must inform the resident if the facility determines that the physician chosen by the resident is unable or unwilling to meet requirements specified in this part and the facility seeks alternate physician participation to assure provision of appropriate and adequate care and treatment. The facility must discuss the alternative physician participation with the resident and honor the resident's preferences, if any, among options.
- The resident has a right to be treated with respect and dignity.
- The resident has a right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.
- The resident has a right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.
- The resident has a right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.
- The resident has a right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement.
- The resident has a right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement.
- The resident has a right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed.
- The resident has a right to refuse to transfer to another room in the facility, if the purpose of the transfer is solely for the convenience of staff (note: a resident's

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exercise of the right to refuse transfer does not affect the resident's eligibility or entitlement to Medicare or Medicaid benefits).

- The resident has a right to and the facility must promote and facilitate resident self-determination through support of the resident.
- The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, plan of care and other applicable provisions.
- The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.
- The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.
- The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident.
- The facility must provide immediate access to any resident by any representative of the Secretary; any representative of the State; any representative of the Office of the State long term care ombudsman; the resident's individual physician; any representative of the protection and advocacy systems, as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000; any representative of the agency responsible for the protection and advocacy system for individuals with a mental disorder (established under the Protection and Advocacy for Mentally Ill Individuals Act of 2000; the resident's representative
- The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time.
- The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time.
- The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.

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- The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation.
- The facility must inform each resident (or resident representative, where appropriate) of his or her visitation rights and related facility policy and procedures, including any clinical or safety restriction or limitation on such rights, consistent with the requirements of this subpart, the reasons for the restriction or limitation, and to whom the restrictions apply, when he or she is informed of his or her other rights.
- The facility must inform each resident of the right, subject to his or her consent, to receive the visitors whom he or she designates, including, but not limited to, a spouse (including a same-sex spouse), a domestic partner (including a same-sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time.
- The facility must not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.
- The facility must ensure that all visitors enjoy full and equal visitation privileges consistent with resident preferences.
- The resident has a right to organize and participate in resident groups in the facility.
- The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner.
- Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation.
- The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings.
- The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.

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- The resident has a right to participate in family groups.
- The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.
- The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.
- The resident has a right to choose to or refuse to perform services for the facility and the facility must not require a resident to perform services for the facility. The resident may perform services for the facility, if he or she chooses, when the facility has documented the resident's need or desire for work in the plan of care; the plan specifies the nature of the services performed and whether the services are voluntary or paid; compensation for paid services is at or above prevailing rates; the resident agrees to the work arrangement described in the plan of care.
- The resident has a right to manage his or her financial affairs; this includes the right to know, in advance, what charges a facility may impose against a resident's personal funds.
- The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility.
- In general the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account (note: in pooled accounts, there must be a separate accounting for each resident's share); the facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund.
- Residents whose care is funded by Medicaid - the facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account; (note: in pooled

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accounts, there must be a separate accounting for each resident's share); the facility must maintain personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund.

- The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf (note: the system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident; the individual financial record must be available to the resident through quarterly statements and upon request).
- The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person; if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.
- Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law.
- The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.
- The facility must not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts) (note: the facility may charge the resident for requested services that are more expensive than or in excess of covered services).
- During the course of a covered Medicare or Medicaid stay, facilities must not charge a resident for the following categories of items and services: nursing services as required; food and nutrition services as required; an activities program as required; room/bed maintenance services; routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized

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cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing assistance, and basic personal laundry; medically-related social services as required; hospice services elected by the resident and paid for under the Medicare Hospice Benefit or paid for by Medicaid under a state plan (note: hospice may refer to a public agency or private organization or subdivision that is primarily engaged in providing hospice care; hospice care may refer to a comprehensive set of services, identified and coordinated by an interdisciplinary group to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient and/or family members, as delineated in a specific patient plan of care).

- The facility can only charge a resident for any non-covered item or service if such item or service is specifically requested by the resident.
- The facility must not require a resident to request any item or service as a condition of admission or continued stay.
- The facility must inform, orally and in writing, the resident requesting an item or service for which a charge will be made that there will be a charge for the item or service and what the charge will be.
- The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility.
- The resident has the right to access personal and medical records pertaining to him or herself.
- The facility must provide the resident with access to personal and medical records pertaining to him or herself, upon an oral or written request, in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format when such records are maintained electronically); or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, within 24 hours (excluding weekends and holidays).

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- The facility must allow the resident to obtain a copy of the records or any portions thereof (including in an electronic form or format when such records are maintained electronically) upon request and two working days advance notice to the facility. The facility may impose a reasonable, cost-based fee on the provision of copies, provided that the fee includes only the cost of: labor for copying the records requested by the individual, whether in paper or electronic form; supplies for creating the paper copy or electronic media if the individual requests that the electronic copy be provided on portable media; postage, when the individual has requested the copy be mailed.

- The facility must ensure that information is provided to each resident in a form and manner the resident can access and understand, including in an alternative format or in a language that the resident can understand; summaries that translate applicable information may be made available to the patient at their request and expense in accordance with applicable law.

- The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands.

- The facility must furnish to each resident a written description of legal rights which includes: a description of the manner of protecting personal funds; a description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act; a list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; a statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community; information and contact information for State and local advocacy organizations, including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the

Older Americans Act of 1965, and the protection and advocacy system; information regarding Medicare and Medicaid eligibility and coverage; contact information for the Aging and Disability Resource Center or other No Wrong Door Program; contact information for the Medicaid Fraud Control Unit; information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.

- The facility must post, in a form and manner accessible and understandable to residents, and resident representatives a list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; a statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.
- The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard; this includes the right to retain and use a cellular phone at the resident's own expense.
- The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: a telephone, including TTY and TDD services; the internet, to the extent available to the facility; and stationery, postage, writing implements and the ability to send mail.
- The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: privacy of such

communications consistent with this section; and access to stationery, postage, and writing implements at the resident's own expense.

- The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for Internet research.
- The resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.
- The resident has the right to receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.
- The facility must post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility.
- The facility must have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the three preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request.
- The facility must post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.
- The facility should not make available identifying information about complainants or residents.
- The facility must inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.
- The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.
- A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s), when there is an accident involving the resident which results

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in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); a need to alter treatment significantly (that is, a need to discontinue or change an existing form of treatment due to adverse consequences, or to commence a new form of treatment); a decision to transfer or discharge the resident from the facility.

- A facility must promptly notify the resident and the resident representative, if any, when there is a change in room or roommate assignment; a change in resident rights under Federal or State law or regulations.
- The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).
- The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay.
- The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.
- The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any (note: receipt of such information, and any amendments to it, must be acknowledged in writing).
- The facility must inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; inform each Medicaid-eligible resident when changes are made to the items and services.
- The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/Medicaid or by the facility's per diem rate.

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- Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
- Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
- If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
- The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
- The resident has a right to personal privacy and confidentiality of his or her personal and medical records (note: personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident).
- The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.
- The resident has a right to secure and confidential personal and medical records.
- The resident has the right to refuse the release of personal and medical records except as provided by applicable federal or state laws.
- The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.
- The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and support for daily living safely.

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- The facility must provide a safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible (note: this includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk).
- The facility should exercise reasonable care for the protection of the resident's property from loss or theft.
- The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents; and other concerns regarding their health care facility stay.
- The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have.
- The facility must make information on how to file a grievance or complaint available to the resident.
- The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusion; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with

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grievances, for example, the identity of the resident for those grievances submitted anonymously; issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; as necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concern(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation of any of these residents' rights within its area of responsibility; maintaining evidence demonstrating the results of all grievances for a period of no less than three years from the issuance of the grievance decision.

- A facility must not prohibit or in any way discourage a resident from communicating with federal, state, or local officials, including, but not limited to, federal and state surveyors, other federal or state health department employees, including representatives of the Office of the State Long-Term Care Ombudsman, and any representative of the agency responsible for the protection and advocacy system for individuals with mental disorder, regarding any matter, whether or not subject to arbitration or any other type of judicial or regulatory action.
- The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

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- The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.
- The facility must ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.
- The facility must not employ or otherwise engage individuals who have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.
- The facility must develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property.
- In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.
- In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must have evidence that all alleged violations are thoroughly investigated.
- In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

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- In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within five working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
- The facility must establish and implement an admissions policy.
- The facility must not request or require residents or potential residents to waive their rights as set forth in this subpart and in applicable state, federal or local licensing or certification laws, including but not limited to their rights to Medicare or Medicaid.
- The facility must not request or require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits.
- The facility must not request or require residents or potential residents to waive potential facility liability for losses of personal property.
- The facility must not request or require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility (note: the facility may request and require a resident representative who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources).
- In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility.
- A nursing facility may charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the State plan as included in the term "nursing facility services" so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident's admission or continued stay on the request for and receipt of such additional services.
- A nursing facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a

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Medicaid eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility for a Medicaid eligible resident.

- The resident has the right to receive a notice of special characteristics or service limitations of the facility.
- A nursing facility must disclose and provide to a resident or potential resident prior to time of admission, notice of special characteristics or service limitations of the facility.
- A facility must establish, maintain and implement identical policies and practices regarding transfer and discharge, and the provision of services for all individuals regardless of source of payment.
- The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless: the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; the safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; the health of individuals in the facility would otherwise be endangered; the resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility (note: non-payment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay; for a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid); the facility ceases to operate.
- Before a facility transfers or discharges a resident, the facility must notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; the facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman; record the reasons for the transfer or discharge in the resident's medical record.
- Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the

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resident or resident representative that specifies: the duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; the reserve bed payment policy in the state plan, if any; the nursing facility's policies regarding bed-hold periods.

- A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following: a resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident; the services provided by the facility; eligibility for Medicare skilled nursing facility services or Medicaid nursing facility services.

- The resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously; if a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there.

- The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity.

- At the time each resident is admitted, the facility must have physician orders for the resident's immediate care.

- The resident has the right to voice specific needs.

- A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: identification and demographic information; customary routine; cognitive patterns; communication; vision; mood and behavior patterns; psychosocial well-being; physical functioning and structural problems; continence; disease diagnoses and health conditions; dental and nutritional status; skin condition; activity pursuit; medications; special treatments and procedures; discharge planning; documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); documentation of participation in assessment. The assessment process must include direct observation and

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communication with the resident, as well as communication with licensed and unlicensed direct care staff members on all shifts.

- A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every three months.
- A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review, and revise the resident's comprehensive plan of care.
- Within seven days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: admission assessment; annual assessment updates; significant change in status assessments; quarterly review assessments; a subset of items upon a resident's transfer, reentry, discharge, and death; background (face-sheet) information, if there is no admission assessment.
- Within seven days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.
- The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.
- The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.
- A registered nurse must sign and certify that a resident's assessment is completed.
- Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.
- The resident has the right to a baseline care plan.

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- The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must be developed within 48 hours of a resident's admission; include the minimum healthcare information necessary to properly care for a resident.
- The resident has the right to a comprehensive person-centered care plan.
- The facility must develop and implement a comprehensive person-centered care plan for each resident.
- The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable re-admissions.
- When the facility anticipates discharge a resident must have a discharge summary that includes, but is not limited to, the following: a recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results; a final summary of the resident's status at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative; reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter); a post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment (note: the post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services).
- The resident has the right to quality of life care.
- Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.

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- Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: a resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living; a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives.
- The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.
- Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices.
- The resident has the right to care to prevent pressure ulcers.
- Based on the comprehensive assessment of a resident, the facility must ensure that a resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.
- The resident has the right to receive proper treatment and care to maintain mobility and good foot health.

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- To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and if necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments.
- The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and a resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion; a resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.
- The resident has the right to live and receive care in an environment free from hazards.
- The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.
- The facility must ensure that a resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.
- The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
- Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; is offered sufficient fluid intake to maintain proper hydration and health; and is offered a therapeutic diet when there is a

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nutritional problem and the health care provider orders a therapeutic diet. A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and a resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.

- Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.
- The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences.
- The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences, to wear and be able to use the prosthetic device.
- The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
- The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
- The facility must ensure that residents who are trauma survivors receive culturally-competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.
- The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation,

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use, and maintenance of bed rails, including but not limited to the following elements.

- A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs.
- The resident has the right to physician care.
- The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.
- The facility must provide or arrange for the provision of physician services 24 hours a day, in case of an emergency.
- The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment.
- The resident has the right to behavioral health care and services.
- Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.
- The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population. These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic

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stress disorder, that have been identified in the facility assessment; and implementing non-pharmacological interventions.

- Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; a resident whose assessment did not reveal or who does not have a diagnosis of a mental or psychosocial adjustment difficulty or a documented history of trauma and/or post-traumatic stress disorder does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that development of such a pattern was unavoidable; and a resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.
- The resident has the right to medically-related social services.
- The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.
- The resident has the right to receive medications, when appropriate/deemed necessary by a health care professional.
- The facility must provide routine and emergency drugs and biologicals to its residents (note: the facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse).
- A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.
- Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; residents do not receive

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psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and PRN orders for psychotropic drugs are limited to 14 days (note: if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order).

- The resident has the right to receive care that is free of medication errors.
- The facility must ensure that its medication error rates are not five percent or greater; and residents are free of any significant medication errors.
- The resident has the right to laboratory services, when applicable.
- The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.
- The facility must: provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws; promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders; assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance; and file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory.
- The resident has the right to radiology and other diagnostic services, when applicable.
- The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.
- The resident has the right to 24-hour emergency dental care, when applicable.
- The facility must assist residents in obtaining routine and 24-hour emergency dental care.

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- The resident has the right to a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.
- The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident.
- The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment.
- The facility must employ a qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis.
- The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.
- The facility must include a member of the Food and Nutrition Services staff on the interdisciplinary team.
- Therapeutic diets must be prescribed by the attending physician (note: the attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law).
- Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care.
- There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span.
- Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care.

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- The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks.
- The resident has the right to a safe, sanitary, and comfortable environment that helps prevent the development and transmission of communicable diseases and infections.
- The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.
- The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted; written standards, policies, and procedures for the program; an antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use; a system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.
- The facility must designate one or more individuals as the infection preventionists (IPs) who are responsible for the facility's IPCP.
- The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis.
- The facility must develop policies and procedures to ensure that each resident or the resident's representative receives education regarding the benefits and potential side effects of influenza immunization; each resident should be offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during the aforementioned time period; the resident or the resident's representative has the opportunity to refuse immunization; and the resident's medical record includes relevant documentation.

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- The facility must develop policies and procedures to ensure that each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; the resident or the resident's representative has the opportunity to refuse immunization; and the resident's medical record includes relevant documentation.
- The facility must develop and implement policies and procedures to ensure all the following: when coronavirus disease 2019 (COVID-19) vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; in situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; the resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; and relevant documentation.
- The facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19.
- The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19 (note: staff are considered fully vaccinated if it has been two weeks or more since they completed a primary vaccination series for COVID-19; the completion of a primary vaccination series for COVID-19 is defined as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine).
- Regardless of clinical responsibility or resident contact, the COVID-19 policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: facility employees; licensed practitioners; students, trainees, and volunteers; and

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individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement.

- The COVID-19 policies and procedures must include, at a minimum, the following components: a process for ensuring all staff (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; a process for ensuring that all staff are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; a process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; a process for tracking and securely documenting the COVID-19 vaccination status of all staff; a process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; a process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; a process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; a process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws; a process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and contingency plans for staff who are not fully vaccinated for COVID-19.

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- The resident has the right to ethical care.
- The operating organization for each facility must have in operation a compliance and ethics program.
- The operating organization for each facility must develop, implement, and maintain an effective compliance and ethics program that contains, at a minimum, the following components: established written compliance and ethics standards, policies, and procedures; assignment of specific individuals within the high-level personnel of the operating organization with the overall responsibility to oversee compliance with the operating organization's compliance and ethics program's standards, policies, and procedures, such as, but not limited to, the chief executive officer (CEO), members of the board of directors, or directors of major divisions in the operating organization; sufficient resources and authority to the specific individuals to reasonably assure compliance with such standards, policies, and procedures; due care not to delegate substantial discretionary authority to individuals who the operating organization knew, or should have known through the exercise of due diligence, had a propensity to engage in criminal, civil, and administrative violations under the Social Security Act; the facility takes steps to effectively communicate the standards, policies, and procedures in the operating organization's compliance and ethics program to the operating organization's entire staff; the facility takes reasonable steps to achieve compliance with the program's standards, policies, and procedures; consistent enforcement of the operating organization's standards, policies, and procedures through appropriate disciplinary mechanisms, including, as appropriate, discipline of individuals responsible for the failure to detect and report a violation to the compliance and ethics program contact identified in the operating organization's compliance and ethics program; after a violation is detected, the operating organization must ensure that all reasonable steps identified in its program are taken to respond appropriately to the violation and to prevent further similar violations.
- The resident has the right to reside in a safe environment.
- The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public.

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- A facility must install, at least, battery-operated single station smoke alarms in accordance with the manufacturer's recommendations in resident sleeping rooms and common areas.
- A facility must have a program for inspection, testing, maintenance, and battery replacement that conforms to the manufacturer's recommendations and that verifies correct operation of the smoke alarms.
- A facility must install an approved, supervised automatic sprinkler system.
- A facility must test, inspect, and maintain an approved, supervised automatic sprinkler system.
- An emergency electrical power system must supply power adequate at least for lighting all entrances and exits; equipment to maintain the fire detection, alarm, and extinguishing systems; and life support systems in the event the normal electrical supply is interrupted.
- When life support systems are used, the facility must provide emergency electrical power with an emergency generator (as defined in NFPA 99, Health Care Facilities) that is located on the premises.
- The facility must provide sufficient space and equipment in dining, health services, recreation, living, and program areas to enable staff to provide residents with needed services as required by these standards and as identified in each resident's assessment and plan of care.
- The facility must maintain all mechanical, electrical, and patient care equipment in safe operating condition.
- The facility must conduct regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment (note: when bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible).
- Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents.
- Resident bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms.

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- Resident bedrooms must have direct access to an exit corridor.
- Resident bedrooms must be designed or equipped to assure full visual privacy for each resident.
- Resident bedrooms must have at least one window to the outside.
- Resident bedrooms must have a floor at or above grade level.
- The facility must provide each resident with a separate bed of proper size and height for the safety and convenience of the resident.
- The facility must provide each resident with a clean, comfortable mattress.
- The facility must provide each resident with bedding appropriate to the weather and climate.
- The facility must provide each resident with functional furniture appropriate to the resident's needs, and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident.
- Each resident room must be equipped with or located near toilet and bathing facilities.
- The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from each resident's bedside; and toilet and bathing facilities.
- The facility must provide one or more rooms designated for resident dining and activities.
- The facility must provide a safe, functional, sanitary, and comfortable environment for the residents, staff and the public.
- The facility must establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply.
- The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two.
- The facility must equip corridors with firmly secured handrails on each side.

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- The facility must maintain an effective pest control program so that the facility is free of pests and rodents.
- The facility must establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents.

Section 3 Summary

Health care professionals and residents should be aware of the residents' rights found below:

- Residents have a right to be treated with consideration, respect, and dignity, recognizing each resident's individuality.
- Residents have a right to exercise his or her rights as a resident of a facility and as a citizen or resident of the United States.
- Residents have a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility.
- Residents have a right to freedom from abuse, neglect, exploitation, and misappropriation of property.
- Residents have a right to freedom from physical or chemical restraints.
- Residents have a right to maintain and improve their quality of life.
- Residents have a right to exercise rights without interference, coercion, discrimination, or reprisal.
- Residents have a right to a homelike environment, and use of personal belongings when possible.
- Residents have a right to equal access to quality care.
- Residents have a right to security of possessions.
- Residents have a right to a choice of activities, schedules, health care, and providers, including attending physician.

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- Residents have a right to a reasonable accommodation of needs and preferences.
- Residents have a right to participate in developing and implementing a person-centered plan of care that incorporates personal and cultural preferences.
- Residents have a right to designate a representative to exercise his or her rights.
- Residents have a right to organize and participate in resident and family groups.
- Residents have a right to request, refuse, and/or discontinue treatment.
- Residents have a right to be fully informed of the type of care to be provided, and risks and benefits of proposed treatments.
- Residents have a right to be fully informed of changes to the plan of care, or in medical or health status.
- Residents have a right to be fully informed of rules and regulations, including a written copy of residents' rights.
- Residents have a right to be fully informed of the contact information for the long-term care ombudsman program and the state survey agency.
- Residents have a right to be fully informed of State survey reports and the nursing facility's plan of correction.
- Residents have a right to be fully informed of written notice before a change in room or roommate.
- Residents have a right to notices and information in a language or manner he or she understands (Spanish, Braille, etc.).
- Residents have a right to present grievances without discrimination or retaliation, or fear.
- Residents have a right to prompt efforts by the facility to resolve grievances, and provide a written decision upon request.
- Residents have a right to file a complaint with the long-term care ombudsman program or the state survey agency.
- Residents have a right to access individuals, services, community members, and activities inside and outside the facility.

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- Residents have a right to visitors of his or her choosing, at any time, and the right to refuse visitors.
- Residents have a right to access personal and medical records.
- Residents have a right to access his or her personal physician and representatives from the state survey agency and long-term care ombudsman program.
- Residents have a right to assistance if sensory impairments exist.
- Residents have a right to participate in social, religious, and community activities.
- Residents have a right to manage his or her financial affairs.
- Residents have a right to information about available services and the charges for each service.
- Residents have a right to personal funds of more than $100 ($50 for residents whose care is funded by Medicaid) deposited by the facility in a separate interest-bearing account, and financial statements quarterly or upon request.
- Residents have a right to not be charged for services covered by Medicaid or Medicare
- Residents have a right to privacy regarding personal, financial, and medical affairs.
- Residents have a right to private and unrestricted communication with any person of their choice.
- Residents have a right to privacy during treatment and care of personal needs.
- Residents have a right to appeal the proposed transfer or discharge and not be discharged while an appeal is pending.
- Residents have the right to receive proper treatment and care to maintain mobility and good foot health.
- Residents have the right to 24-hour emergency dental care, when applicable.
- Residents have a right to privacy receive 30-day written notice of discharge or transfer that includes: the reason; the effective date; the location going to; appeal rights and process for filing an appeal; and the name and contact information for the long-term care ombudsman.

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- Residents have a right to preparation and orientation to ensure safe and orderly transfer or discharge
- Residents have a right to return to the facility after hospitalization or therapeutic leave.
- The resident has the right to ethical care.
- The resident has the right to reside in a safe environment.

Section 3 Key Concepts

- Residents' rights, as well as related requirements, regulations, and laws may be found in Title 42 Part 483.

Section 3 Key Terms

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Hospice - a public agency or private organization or subdivision that is primarily engaged in providing hospice care

Hospice care - a comprehensive set of services, identified and coordinated by an interdisciplinary group to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient and/or family members, as delineated in a specific patient plan of care

Section 3 Personal Reflection Question

How can health care professionals ensure the laws, regulations, and requirements included in Title 42 Part 483 are met and followed within an applicable health care facility?

Conclusion

Residents of health care facilities have specific rights protected by law. Health care professionals and residents should be familiar with residents' rights. Finally, residents' rights, as well as related requirements, regulations, and laws may be found in Title 42 Part 483.

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