

***Consumer Handbook
For Residents of
Long-Term Care
Facilities***





Missouri Department of Health and Senior Services

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**Office of the State Long-Term Care Ombudsman
Department of Health and Senior Services
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Dear Resident,

This handbook has been designed for you to use as you move into your new home. It provides you with information and ideas to help you become familiar with your new living situation and how to resolve any questions or concerns. The booklet will also be helpful to your family members when they have questions.

Please feel free to call us if you have any questions about this booklet or if you need help to handle your concerns.

Sincerely,

The Missouri Long-Term Care
Ombudsman Program

www.health.mo.gov

Healthy Missourians for life.

The Missouri Department of Health and Senior Services will be the leader in promoting, protecting and partnering for health.

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER: Services provided on a nondiscriminatory basis.

INTRODUCTION

What is the Long-Term Care Ombudsman Program?

The Long-Term Care Ombudsman Program is Missouri's most comprehensive resource serving residents of long-term care facilities and their families. It was established as an **independent, nonprofit, public service agency** to support and inform the **one out of every two of us** who will spend time in a care facility.

What Information Can I Get From The Ombudsman Program?

Professional staff at the Ombudsman Program inform and assist residents and their families by:

- Helping clarify long-term care facility regulations and resources;
- Providing technical assistance for professionals who work with residents and families; and
- Educating the community about the services of the Ombudsman Program and the rights of long-term care facility residents.

What Does The Ombudsman Program Do?

The Ombudsman Program staff and volunteers are advocates for facility residents who conduct the following activities:

- Listen to residents' concerns and grievances;
- Resolve grievances by working with residents and facility staff;
- Explain the rights of facility residents;
- Promote meaningful conversation and rapport between residents and facility staff; and
- Monitor the development of federal, state, and local laws regarding long-term care and other long-term care issues.

Who Delivers Ombudsman Services?

- Services are provided by professional staff of the state Ombudsman Program that are experienced in working with state government and in negotiating with families.
- Services are also provided by Ombudsman volunteers, who are the foundation of the program and who receive extensive training prior to serving facility residents.
- The Ombudsman Program is independent and impartial—Ombudsmen are not state inspectors and are not facility employees.

INTRODUCTION

How Is The Ombudsman Program Funded?

The Ombudsman Program relies on community resources for much of its funding, including individual gifts, foundation grants, and corporate contributions.

Federal funds are provided under Title III and Title VII of the Older Americans Act via the Area Agencies on Aging.

State funds are appropriated through the Missouri Legislature to the Missouri Department of Health and Senior Services.

Services Of The Ombudsman Program Include The Following:

- ✓ Provide a grievance process accessible to facility residents and their families;
- ✓ Recruit, train, place, and supervise Ombudsman volunteers, assigned to specific long-term care facilities, who respond to resident complaints/concerns and investigate issues with the permission of the resident;
- ✓ Respond to complaints received in the Ombudsman office by advising the caller of the resources available and personally investigating the complaint when necessary;
- ✓ Educate residents and facility staff, residents' families, and the general public about the rights of residents as established by state and federal laws;
- ✓ Distribute and explain residents' rights literature to residents;
- ✓ Supply large print posters depicting the rights of nursing home residents for prominent display in a facility;
- ✓ Conduct residents' rights in-service training for facility staff;
- ✓ Provide staff to discuss information and referral for families seeking long-term care services for a relative; and
- ✓ Provide general information to the community regarding resources available for long-term care, residents' rights, choosing a long-term care facility, Medicaid and Medicare issues, and the Ombudsman Program.

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Chapter 1 - FACILITY TYPES

This chapter includes information regarding the various types of long-term care facilities licensed in Missouri. Each type of facility has varied requirements for being licensed.

The information in this handbook is primarily focused on facilities that provide nursing and medical care; however, the topics also apply to the other facility types in various ways. If you are unsure whether a particular issue applies to the type of facility where you reside, please contact the Ombudsman Program for clarification.

Residential Care Facility

A Residential Care Facility (RCF) provides 24-hour care to three or more residents, who are not related within the fourth degree of consanguinity or affinity to the owner, operator, or manager of the facility and who need or are provided with shelter, board, and with protective oversight, which may include storage and distribution or administration of medications and care during short-term illness or recuperation.

There are two kinds of RCFs licensed by the Department of Health and Senior Services:

RCF Is are licensed to provide 24-hour care for those who need or are provided with shelter, board, and protective oversight and are able to make a path to safety unassisted, or with the use of assistive devices within 5 minutes. A licensed administrator is not required for this type of facility.

RCF IIs are licensed to provide 24-hour accommodation, board and care for residents who may need additional help with diet supervision, personal care assistance, storage, distribution and/or administration of medications, and supervision of health care under the direction of a licensed physician and protective oversight. These residents are also required to make a path to safety without assistance or with the use of assistive devices. A licensed administrator is required.

Not all RCFs are the same, so you need to evaluate which type of RCF will provide the services that you want and need.

Assisted Living Facility

An Assisted Living Facility (ALF) is a facility that provides 24-hour care and services and protective oversight to three or more residents who are provided with shelter, board, and who may need and are provided with assistance with any activities of daily living and any instrumental activities of daily living; storage, distribution, or administration of medications; and supervision of health care under the direction of a licensed physician, provided that such services are consistent with a social model of care. A social model of care means providing services based on the abilities, desires, and functional needs of residents delivered in a homelike setting. Residents receiving hospice care may reside in an ALF.

There are two kinds of ALFs licensed by the Department of Health and Senior Services. All ALFs are required to have a licensed administrator.

Chapter 1 - FACILITY TYPES

ALF Is provide 24-hour care, services and protective oversight for those who may need assistance with eating, dressing, bathing, toileting, transferring, and walking. The facility also provides oversight for the storage, distribution, or administration of medications.

The facility will provide health care supervision under the direction of a licensed physician and consistent with the social model of care. This type of facility may admit or retain residents who require minimal assistance in their safe evacuation from the facility.

ALF IIs provide 24-hour care, services and protective oversight for those who may need assistance with eating, dressing, bathing, toileting, transferring and walking. The facility also provides oversight for the storage, distribution or administration of medications. The facility will provide health care supervision under the direction of a licensed physician and consistent with the social model of care. The facility **may** admit or retain residents who require more than minimal assistance to evacuate the facility only if the facility meets certain staffing requirements to assist in evacuations and includes an individualized evacuation plan in the resident's service plan.

What is minimal assistance?

Minimal assistance may be a verbal or physical intervention that staff provide for a resident to evacuate the facility. A resident who needs minimal assistance is one who is able to prepare to leave and evacuate the facility within five minutes of being alerted to the need to evacuate. This resident requires no more than one physical intervention or no more than three verbal interventions to evacuate the building.

What is considered to be more than minimal assistance?

The following actions of staff are considered to be more than minimal assistance:

1. Assistance to go down stairways.
2. Assistance to open a door.
3. Assistance to use a wheelchair.

Are there situations where an individual may not qualify for admission to an ALF?

Yes. The following criteria would disqualify individuals from admission:

1. The individual is bed-bound or similarly immobilized (except for those individuals who receive hospice care, provided the resident, his/her legal representative, the facility, physician and licensed hospice provider agree hospice is appropriate for the resident).
2. The individual exhibits behaviors that present a reasonable likelihood of serious harm to self or others.
3. The individual requires a physical or chemical restraint.
4. The individual requires more than one person to physically assist with activities of daily living, with the exception of bathing and transferring.

ALFs are required to develop a written contract coordinating oversight and services to meet the resident's needs in accordance with the resident's individualized service plan. The written contract must be signed by the resident or by a legal representative of the resident.

Chapter 1 - FACILITY TYPES

Intermediate Care Facility

Intermediate Care Facilities (ICF) are any premises, other than a Residential Care Facility, Assisted Living Facility, or Skilled Nursing Facility, which are utilized by the owner, operator, or manager to provide 24-hour accommodation, board, personal care, and basic health and nursing care services under the daily supervision of a licensed nurse and under the direction of a licensed physician to three or more residents dependent for care and supervision and who are not related within the fourth degree of consanguinity or affinity to the owner, operator or manager of the facility. A licensed administrator is required.

Skilled Nursing Facility

Skilled Nursing Facilities (SNF) are any premises, other than a Residential Care Facility, Assisted Living Facility or Intermediate Care Facility, which are utilized by the owner, operator or manager to provide for 24 hour accommodation, board and skilled nursing care and treatment services to at least three residents who are not related within the fourth degree of consanguinity or affinity to the owner, operator or manager of the facility. Skilled nursing care and treatment services are those services commonly performed by or under the supervision of a registered professional nurse for individuals requiring 24 hour a day care by licensed nursing personnel, including acts of observation, care and counsel of the aged, ill, injured or infirm, the administration of medications and treatments as prescribed by a licensed physician or dentist and other nursing functions requiring substantial specialized judgment and skill. A licensed administrator is required.

Chapter 2 – ADMISSION AGREEMENT

This chapter talks about what should be included in your admission package. Be sure you receive a copy of each document when you move in.

Admission Agreement:

Your Admission Agreement is an important document because it spells out information about your stay at the facility, including daily rates, covered services, refunds, etc. This information must be given to you in a form you understand.

Do you have a copy of your admission agreement?

YES NO

Talk with the staff to obtain a copy. The facility must inform you of its policies when you move in and before making any changes to them.

Covered Services:

The Admission Agreement should include a list explaining what services are covered under your daily rate and what extra charges may be billed to you, such as assistance with eating and therapy.

Do you have a copy of the list explaining services and charges?

YES NO

Talk to the staff if you have any questions.

If you are a Medicaid participant, **see Appendix A** for a list of all services and supplies that are provided by the nursing home at no extra cost to you.

Bed Hold Policy:

The Bed Hold Policy explains the terms for holding your bed when you are in the hospital or out of the facility overnight. It should include the daily rate you will be charged to save your bed.

Do you have a copy of the Bed Hold Policy?

YES NO

If you receive Medicaid and decide not to pay to save your bed, the facility must provide the first available Medicaid bed to you when you return. Medicaid will pay to hold your bed if you are in the hospital for 3 nights or less AND if the facility is at least 97% occupied.

Chapter 2 – ADMISSION AGREEMENT

Advance Directives:

Advance Directives are documents stating whether or not you wish to receive certain medical treatment and who can make health care decisions for you.

Do you have a copy of the facility's policy about advance directives? Find out if the facility will honor your wishes and choices BEFORE you move in.

YES NO

If you do not understand the facility's policy or have questions about advance directives, contact facility staff for help.

Do you have an advance directive?

YES NO

Make sure to give the facility and your doctor a copy of your advance directive.

Neither the facility nor your doctor can force you to make an advance directive if you do not want one.

Contact facility staff, your attorney or the local Legal Services Office if you need more information about advance directives.

Responsible Party:

A Responsible Party is a person the facility can call about your care needs and/or finances.

Has anyone signed papers to become your responsible party?

YES NO

The facility cannot require that person to guarantee payment to the facility as a condition for you to enter or stay in the facility. However, the facility may require an individual who has legal access to your income or resources to sign a contract, without incurring personal financial liability, to provide facility payment from your income or resources.

Restraint Policy:

Federal law limits the use of physical and chemical restraints in long-term care facilities. Many facilities ask residents to sign a Restraint Policy which states when and how restraints are used in the facility.

Do you have a copy of the facility's restraint policy and do you understand it?

YES NO

Talk to the nurse about restraints and how they are used in the facility. Ask for a copy of the facility's restraint policy if you do not have it.

Note: The use of restraints is NOT allowed in residential care or assisted living facilities.

Chapter 2 – ADMISSION AGREEMENT

Medicare:

Medicare coverage for staying in a long-term care facility is very limited and seldom covers all the costs of care.

Does Medicare cover the cost for me to stay at the facility?

YES NO

Make sure you know the number of days you are allowed. Otherwise, you may have to pay extra.

See **Appendix B** for more information on Medicare benefits.

Medicaid:

Medicaid (MO HealthNet) is a state program that may pay for your care in a facility if you cannot pay the full price by yourself.

Do you need help to pay for your care?

YES NO

You need to talk with facility staff about qualifying for Medicaid and whether or not the facility has Medicaid beds available.

Appendix B gives more information about Medicaid benefits.

Making Decisions:

No one can make personal or financial decisions for you unless you agree or a court appoints a guardian for you. You do not have to have a guardian, responsible party, or give someone your power of attorney in order to live in a facility.

Do you make your own decisions regarding your health care needs?

YES NO

The only other people who can make health care decisions for you are those you have appointed through a Durable Power of Attorney for Health Care or someone who is a court-appointed guardian.

Are you able to handle your own finances?

YES NO

You can appoint someone to help you by completing a Power of Attorney, Durable Power of Attorney, or the court can appoint a guardian or conservator.

Does someone else receive your Social Security check?

YES NO

If so, you probably have a Representative Payee to receive the check. This does not mean that person has any authority to make decisions for you regarding health care or finances.

Chapter 2 – ADMISSION AGREEMENT

Residents' Rights:

You have the right to a dignified existence and self-determination, and the facility must promote and protect your rights. A written copy of your rights should be given to you at the time you move in.

Did you receive a copy of your rights?

YES NO

Contact facility staff or the Ombudsman Program for more information about your rights.

Assessment:

If you are assigned to a Medicaid bed, whether or not you receive Medicaid benefits, the facility must do a complete assessment of your needs when you move in.

Did you take part in the assessment when you moved into the facility?

YES NO

If you are not sure, ask facility staff about it. The facility must complete a form called the Minimum Data Set (MDS) within 14 days of the day you moved into the facility. This form helps the facility look at all of your needs, including medical, emotional and social issues.

The assessment must be updated when your physical or mental condition changes, such as after a hospital stay, and at regular intervals during the year.

Did the facility complete a new assessment when your condition changed, or at any other time?

YES NO

Ask the facility to review your assessment with you. This information must be given to you upon request.

Care Plans:

A care plan must be done within 7 days of your assessment. The purpose of a care plan is to set goals which help meet your medical and emotional needs.

Did you actively participate in your care plan meeting?

YES NO

Remember that this meeting is held specifically so you can participate in your care. You should use this time to voice any concerns you have about your care. Ask when your next care plan meeting is scheduled and plan to attend it.

Chapter 3 – RESIDENTS’ RIGHTS

This chapter talks about your right to be treated with dignity and respect while living in a facility. It also explains your right to be protected from abuse, to communicate with others, and to be provided privacy and confidentiality.

Possessions:

I have pictures on my walls and personal possessions/items in my room.

YES NO

If you want personal belongings with you, talk to facility staff. The facility must provide you with enough space to keep a reasonable amount of your personal items.

The facility has a list of all my personal belongings.

YES NO

Ask your family or the facility to make a list. The facility is required to keep an inventory list of your personal possessions for loss and theft purposes. It should be updated on a regular basis when a new item is brought to you or something is removed from your room.

Resident Funds:

The facility has my permission to handle my money, including my personal needs allowance and other money I receive.

YES NO

You have to give written permission for this to be done. If you are in a Medicare or Medicaid bed, you can request the facility to hold money for you. They must put any amount over \$50 into an interest-bearing account.

Do you receive a written financial statement from the facility each quarter?

YES NO

You should receive a statement regularly and review it to make sure your money is spent only with your permission and for your needs. The facility must provide you information any time you request it during regular business hours Monday through Friday.

Does the facility allow you to withdraw your funds when you ask?

YES NO

The facility must allow you to withdraw any amount of money from your account, regardless of how you plan to spend it.

Does my family or anyone else use money from my account without my permission?

YES NO

No one can use your money unless you first give the facility written permission to give the money to that person (including facility staff).

Chapter 3 – RESIDENTS’ RIGHTS

Restraints:

I receive a medication that makes me tired.

YES NO

If you are concerned about this, talk to your doctor and the facility’s Director of Nursing. Certain medications *may be* a chemical restraint. Chemical restraints are drugs that cause you to be tired and inactive.

I am often left tied in my chair or bed.

YES NO

Any time you are limited in activities, such as being tied in a wheelchair or bed, you are being physically restrained. Unless your doctor ordered this and you have agreed to it, it is against the law.

If you feel you are being restrained unnecessarily, talk with your doctor and the facility’s Director of Nursing. Call the **Elder Abuse and Neglect Hotline at 1-800-392-0210** if you feel the doctor or facility is not responding to you.

You can also call the **Ombudsman Program at 1-800-309-3282** to request help.

Room Changes:

I am being forced to change my room because of my Medicare or Medicaid bed.

YES NO

You cannot be made to move into a Medicare bed even if you are eligible for Medicare benefits. However, you cannot get Medicare benefits if you are not in a Medicare bed. On the other hand, if the bed is *only* a Medicare bed and you are a Medicaid recipient, you would have to move from the Medicare bed back to a Medicaid bed. If your bed is both a Medicare and Medicaid bed, you cannot be forced to move just because your Medicare benefits have ended.

I have had my room changed often.

YES NO

You must be consulted before any room transfer and there must be a valid reason for the move. If this is a recurring problem, talk to facility staff, the state surveyors, or the Ombudsman Program for assistance.

If you and your spouse both reside in the facility, you have the right to share a room if both of you agree that’s what you want.

Chapter 3 – RESIDENTS’ RIGHTS

Services:

I want to use my own doctor and pharmacy.

YES NO

Make sure your doctor will visit the facility or that you have transportation to the doctor’s office. Many doctors will not visit you at the facility, especially if you are a Medicaid recipient.

You can use any pharmacy you wish. There may be some special needs regarding the packaging of prescriptions that must be followed. All other supplies, such as incontinence pads, may be purchased from the supplier of your choice.

If you are a Medicaid recipient, **refer to Appendix A** for a list of items covered under the facility’s daily rate.

Records:

I want to see my medical records.

YES NO

The facility must make these available to you upon your verbal or written request. If you want copies, the facility must provide them within 2 working days at minimal cost. The cost can include staff time. Be sure to ask what the cost will be.

Choice:

I am forced to take part in activities or I want to have different activities.

YES NO

Tell the activity director or other facility staff what your interests are and which activities would interest you. Also discuss this at your next care plan meeting. You cannot be forced to participate in activities.

I want to get up at a different time in the morning.

YES NO

Let facility staff know what time you wish to get up in the morning. The facility should work with you to find a time that meets your preference and include it in your care plan.

I want to take a bath/shower at a different time or on a different day.

YES NO

Tell the nurse or other staff what day and time you want to bathe, so the time can be changed to meet your request.

Chapter 3 – RESIDENTS’ RIGHTS

Visitors:

Does the facility limit your visitors?

YES NO

Your family and friends have the right to visit you whenever it is convenient. You can refuse to see a visitor, but no one else is allowed to refuse on your behalf. A court-appointed guardian can restrict your visitors, but only for a valid reason. The person appointed as your health care agent in a Durable Power of Attorney for Health Care may only restrict visitors for medical reasons.

Ombudsman:

I want to see an Ombudsman.

YES NO

Contact your local Ombudsman office and request that an Ombudsman visit you. Refer to the regional map in the back of this booklet for contact information. Facility staff will help you make the call.

Facility Surveyor:

I want to see a facility surveyor.

YES NO

Look for a sign posted on the front door that says the Department of Health and Senior Services, Section for Long-Term Care Regulation is doing an inspection. While they are at the facility, you can discuss any concerns you have with them.

If you wish to talk to an inspector at another time, call the Elder Abuse and Neglect Hotline at **1-800-392-0210**.

I read the facility inspection reports.

YES NO

The facility is responsible for posting the results of the inspection in an area easily accessible to residents and visitors. You can also request to see a copy of the inspection report.

Chapter 3 – RESIDENTS’ RIGHTS

Abuse:

I believe I was abused.

A staff member yelled at me.

YES NO

Any time a staff person yells at or uses inappropriate language with a resident it is considered verbal abuse. Report this and all other incidents of suspected abuse to the administrator and your family at once.

You may also report abuse to the Ombudsman Program at **1-800-309-3282** or to the Elder Abuse and Neglect Hotline at **1-800-392-0210**.

I was slapped or physically hurt by a staff member.

YES NO

There is absolutely no reason for someone to physically abuse you in any way. Notify your family and the facility administrator immediately.

This must also be reported to the Elder Abuse and Neglect Hotline at **1-800-392-0210**. The DHSS/Section for Long-Term Care Regulation will follow-up on the incident.

For your own protection, report abuse immediately!

A staff member dropped me while helping me out of bed.

YES NO

This may or may not be a form of abuse.

If you think it was done on purpose, report the incident to the administrator, your family, and the Elder Abuse and Neglect Hotline. If you feel it was an accident, ask that your family be notified. Make sure nursing staff have been informed and that facility staff are trained to handle you properly.

Any injury of *unknown origin* should be reported to the Elder Abuse and Neglect Hotline, even if you are not sure whether you should call.

Note: No matter who calls the Elder Abuse and Neglect Hotline, the name of the reporter remains confidential. Reports can also be made anonymously.

Chapter 4 – FAMILY RIGHTS

This chapter provides information regarding family rights when your loved one moves to a long-term care facility. It is important that you understand and use these rights to advocate for your family member.

In the past, facility staff often looked to family members to determine a resident's needs. That emphasis has now changed to helping the resident make his or her own decisions regarding care. Even if you feel the resident is making a bad decision, you must respect their right to do so. The only time you can make decisions for a family member is if you are given legal authority to do so.

Family rights include the following categories:

Assessment – Family members have the right, with the resident's permission, to be included in the resident assessment. The assessment gives the facility vital information about the resident. In order for this information to be complete, family members should have some input in the process.

Care Plan Meetings – Family members have the right, with the permission of the resident, to be included in the care plan meeting provided by the facility on behalf of the resident. The care plan meeting provides a review of the resident's progress in the facility, outlines future treatment, and deals with any special problems or concerns regarding the resident. Care plan meetings are to be held quarterly or whenever there is a change in the resident's condition. Talk to the social service designee or other facility staff to determine when the care plan meeting will be held.

Notification – A family member has the right to be notified within 24 hours of the following: any accident involving the resident; any significant change in the physical or mental needs of the resident; the need to change treatment of the resident; any decision to transfer or discharge the resident and the reason for such action; a change in the resident's room or roommate; and/or any change in resident rights.

Family Councils – Family members are allowed to meet with other family members in an area provided by the facility. Staff do not have to be present, but the facility must designate a staff person who is responsible for acting on grievances and/or recommendations made by the family council.

Inventory List – Family members are allowed access to the resident's personal property inventory list in order to add or delete items as necessary. Items may only be removed from the facility with the resident's permission.

Visiting – Family members are to be provided with immediate and unlimited access to the resident, as long as the resident agrees to see them.

Chapter 4 – FAMILY RIGHTS

Bed Hold – Family members are to receive a copy of the facility’s Bed Hold Policy after a resident has moved into the facility. For residents in a Medicaid bed, a written copy of the policy must also be provided within 24 hours of the resident being transferred to a hospital from the facility.

Resident Funds – Family members are **not** allowed access to the resident’s funds without written permission from the resident. If you wish to make purchases for the resident using the resident’s funds, you will have to provide receipts to the facility before being reimbursed. Only the resident or the resident’s legal representative is entitled to an accounting of the resident’s funds held by the facility. This accounting should be provided automatically on a quarterly basis.

Responsible Party – If you sign admission papers agreeing to be a responsible party for the resident, be sure you determine whether or not this includes being financially responsible. The facility cannot require you to guarantee payment to the facility as a condition for the resident to enter or stay in the facility.

However, the facility may require an individual who has legal access to the resident’s income or resources to sign a contract, without incurring personal financial liability, to provide facility payment from the resident’s income or resources.

Chapter 5 – TRANSFER AND DISCHARGE

This chapter explains the process for completing transfers or being discharged from a long-term care facility.

Reasons for Transfer and Discharge

For the purposes of this booklet, the following definitions apply:

Transfer – being transferred from the current facility to another location, such as a hospital or other care setting.

Discharge – the facility and/or resident decides that the resident can no longer remain in that facility.

You cannot be transferred or discharged unless:

- It is necessary for your welfare and the facility cannot meet your specific needs;
- Your health has improved and you do not need to be in the facility;
- The health and safety of other residents and staff is endangered if you remain in the facility;
- Payment is not made on your behalf to the facility, whether it is from your own funds, from family, or by Medicare or Medicaid; or
- The facility closes.

Note: If the transfer or discharge is due to your needs not being met, improvement of your health, or for the welfare of others, your doctor must document this information in your medical records.

Notice Required

The facility must provide the following information prior to transfer or discharge (unless an emergency situation exists):

- Written notice at least 30 days before the effective date;
- The specific reason for transfer or discharge;
- The effective date;
- Where you will be going;
- Information on your right to appeal the transfer or discharge with the name and address where the appeal must be mailed; and
- The name, address, and telephone number of your Regional Ombudsman Program.

If the letter does not include all of the above, it is not valid and should be returned to the facility with a request for the correct information with a new effective date.

Chapter 5 – TRANSFER AND DISCHARGE

If you wish to appeal the transfer or discharge, you will be allowed to stay in the facility until the appeal has been heard. Contact the office of the State Long-Term Care Ombudsman at 1-800-309-3282 if you have any questions.

The facility must also notify your family or legal representative that you are being transferred or discharged. If you have no family or legal representative, the facility must notify the Regional Ombudsman Program.

The long-term care facility must ensure your safety by making appropriate preparations prior to the transfer or discharge. They should discuss all aspects of the move with you and your family. Facility staff should also help you locate a new place to live, if needed.

Emergency Transfers

Emergency transfers are permitted and do not require a 30 day written notice, although the facility must give you a written notice.

Circumstances that might cause emergency transfers include:

- Other individuals in the facility are at immediate risk;
- Your health has improved and you are able to leave the facility immediately;
- You require immediate medical attention; or
- You have not resided in the facility for more than 30 days.

If you believe you are being transferred or discharged from the facility without a valid reason, or you do not understand the transfer or discharge process, contact the office of the State Long-Term Care Ombudsman at 1-800-309-3282 or the Elder Abuse Hotline at 1-800-392-0210.

Private Pay Residents

Individuals who pay for all of their care from their own funds must give the facility prior notice before leaving. The length of time required for adequate notice should be included in the admission agreement.

When Residents Want To Return To The Community

Many individuals move to a long-term care facility after a critical illness. They may need medical monitoring, therapy and other services to help regain their strength. Even when someone has lived in a facility for months or years, their condition may improve enough to consider returning to their own home or to another setting for independent living.

The facility is required to talk to each resident about the possibility of discharge from the facility and if the resident would like to talk to someone about their options. If the resident does want to leave, facility staff will make a referral for someone to talk with the resident about their community options and support needs. The resident can also call the Ombudsman Program for help returning to a community setting.

Chapter 6 - COMPLAINTS

This chapter explains the steps that should be taken when you have a complaint about the care you receive while living in a long-term care facility.

There may be times when you have a concern or complaint about the way you are being treated or cared for in a long-term care facility. These concerns need to be brought to the attention of facility staff so a solution can be found.

Making a Complaint

When talking to facility staff about a problem or complaint, try to be factual without becoming emotional. The more facts you can provide to support your complaint, the better the facility will understand your point of view. You will also have a better conversation with facility staff if you remain calm while discussing the issue.

Put your complaint or concern in writing and include the following:

- Time of day the incident occurred.
- Names of all people involved.
- How often the problem happens.
- Names of anyone who saw or heard the incident.
- Any other details you feel would help describe what happened.

Every long-term care facility must have a staff person designated to accept and respond to your concerns or complaints. This person is allowed 3 days from receipt of your complaint to provide you with a written response.

- Check with the facility to see which staff person is designated to handle in-house complaints. This will usually be the social worker or the administrator.

Common Complaints

Missing clothes – Did the item have your name on it? Was it on your inventory list? Have you checked the laundry lost and found? Has a staff member checked your roommate's closet and drawers? Are other residents or staff wearing the item?

If you have checked these possibilities but have not found the items, make a complaint through the facility's in-house complaint reporting system.

Missing items – Such as a radio, television, jewelry, money, etc. Record the date and time you realize it's gone. Make a police report. File a complaint through the facility's in-house process. Ask for a locked drawer in your room.

Talk to the resident council to see if this has happened to other residents. Have a family member bring up the problem at a family council meeting.

Chapter 6 - COMPLAINTS

Food issues

- Food is cold: Does it sit out too long before being served? Does it take too long to get help to eat? Do you need assistive devices?
Tell dietary staff you need help to eat. Ask for adaptive tools for eating. Talk to dietary or nursing staff to get the help you need.
- Not enough food: Ask for a second helping. Ask for substitute food items. Ask for snacks. Consult your doctor about a change in diet. Talk to dietary staff about receiving larger portions or reevaluating your needs.
- Dislike the food: Ask for different food items. Talk to dietary staff about your likes and dislikes and have them write this down in your record.
- Weight loss: Mention your concerns at care plan meetings. Do you have dental problems? Do you need more help to feed yourself?

If these suggestions do not take care of your concern, file a complaint with the facility's designated staff person, talk to your Volunteer Ombudsman, or call the State Long-Term Care Ombudsman Program at 1-800-309-3282.

Roommates

Figure out the exact nature of the problem. Speak with facility staff about the problem, ask what can be done, or if you can change roommates. Ask for a private room, if available. Follow up on the availability of another room weekly.

Let the facility know if there is another resident that you would like as a roommate. Talk to facility staff during your care plan meeting.

The facility must respond to your request, but there will be limits on how often they will be able to move you or the roommate to another room. Even if you lived in the room first, you may be the one who has to move in order to make the change.

Financial

- Billing questions: Request an itemized statement if you have questions about a bill. Find out if the item is covered by your daily rate by looking at your admission agreement. Check the list of covered items and services in Appendix A of this booklet.
- Personal funds: Request an itemized statement of payments made with your funds. Ask for copies of all receipts. Make sure you gave permission for any money to be spent. Be sure the item or expense was not a covered item listed in Appendix A. Talk with the bookkeeper at the facility.

If you requested the facility to hold your personal funds, they are responsible for making sure the money is spent only for items you authorize. They must provide an accounting of your money upon request and at least quarterly.

Chapter 6 - COMPLAINTS

Resident Care

Wet bedding: Does staff respond to your call light in a timely manner? Can you reach your call light? Do you know how to use the call light? Do you have trouble controlling your bowel and bladder? Do you need help to control your bowel and bladder?

If it takes too long for staff to respond to your call light, talk to the nurse and the staff person designated to handle complaints. Try to show the nurse the wet bedding and write down how long the bedding is left wet. Be sure you know how to use the call light and that staff place it close enough for you to reach.

If the problem is because you have trouble controlling your bowel and bladder or other medical issues, you will need to talk to the director of nursing and/or contact your doctor for help.

Skin Breakdown

Skin breakdown can be caused by lying too long in one position without being turned. It can also be caused by skin staying wet for too long a time. Affected areas become red and blistered and must be treated so they do not become worse. Common areas to find skin breakdown are on the elbows, knees, hips and buttocks. If you notice redness or pain in these areas or any other, you should:

Tell the staff immediately so they can check the area.

Tell your family so they can help you take care of the situation.

Ask facility staff if they have notified your doctor about the problem.

Be sure you are being turned at least every 2 hours, if ordered by your doctor.

If the affected area gets worse, notify your doctor immediately. If the facility staff and your doctor do not take care of it, ask your family to call the doctor for you.

- Skin breakdown is a very serious condition that can lead to hospitalization. It needs to be treated quickly and monitored on a regular basis.

If necessary, call the **Elder Abuse and Neglect Hotline at 1-800-392-0210** to get help.

Medical Care

If your medical condition or behavior changes, check the following:

Have you made facility staff aware of the changes? Has your doctor been notified? Do you need to see the doctor? Have your medications been changed recently? Does an assessment need to be done to evaluate your behaviors? Has the facility set up a care plan meeting to address the changes?

Chapter 6 - COMPLAINTS

Your medical and emotional health is a major concern. The facility must notify the doctor and your family when your health changes. Consider choosing a new doctor if your current doctor cannot help.

- Always insist the facility hold a care plan meeting to make sure any changes are discussed and treated appropriately.
- Ask your family to help you monitor your care so when a problem occurs it does not develop into a life-threatening situation.
- If you feel a change is life-threatening and you are not getting a response from the facility, call the **Elder Abuse and Neglect Hotline at 1-800-292-0210**.

Abuse

If you feel you are being abused:

- Tell your family immediately.
- Notify the facility administrator immediately.
- Call the **Elder Abuse and Neglect Hotline at 1-800-392-0210** immediately.
- Request that facility staff complete an incident report and provide copies to you and your family.

Any time abuse is suspected it must be reported to the Hotline. Try to remember when and where it happened and who was involved so you can provide this information to anyone investigating the abuse.

If a family member suspects abuse, they should look for bruises, cuts, marks, behavior changes, and other signs there might be a problem. Always report suspected abuse situations.

Complaint Follow-up

With all complaints, the facility should give you a time limit for resolving the complaint. You should follow-up with the facility regularly about the progress being made.

Bring the complaint up during your care plan meeting to help ensure the complaint will become part of your record. This will help you get a commitment from the facility.

If you feel that other facility staff are not making progress with your complaint, speak to the administrator about it. Always provide as much information as possible, in writing, and keep copies for yourself.

Another option available to you is moving to another long-term care facility. This may seem like a drastic solution, but it could be the most logical choice depending on your needs.

Chapter 6 - COMPLAINTS

Remember: If the facility does not resolve your concerns with the in-house process or follow-up, the Ombudsman Program will help you. Contact your local Volunteer Ombudsman, your Regional Ombudsman Office, or the office of the State Long-Term Care Ombudsman at **1-800-309-3282**.

Appendix A

These items are covered under the Medicaid per diem (daily) rate.

Personal Care

Baby Powder
Bedside Tissues
Bib (all types)
Deodorants
Disposable Underpads (all types)
Gowns, Hospital
Hair Care, Basic (includes washing, sets, brushes, combs, nonlegend shampoo)
Lotion, Soap and Oil
Nail Clipping and Cleaning
Oral Hygiene (including denture care, cups, cleaners, mouthwashes, toothbrushes and paste)
Shaves, Shaving Cream, and Blades

Equipment

Arm Slings
Basins
Bathing Equipment
Bed Frame Equipment (including trapeze bars and bedrails)
Bed Pans (all types)
Beds, manual, electric
Canes (all types)
Crutches (all types)
Foot Cradles, all types
Glucometers
Heat Cradles
Heating Pads
Hot Pack Machines
Hypothermia Blanket
Mattresses (all types)
Patient Lifts (all types)

Respiratory Equipment (compressors, vaporizers, humidifiers, intermittent positive pressure breathing machines (IPPB), nebulizers, suction equipment and related supplies, etc.)

Restraints
Sand Bags
Specimen Container (cup or bottle)
Urinals (male and female)
Walkers (all types)
Water Pitchers
Wheelchairs (standard, geriatric, and rollabout)

Nursing Care/Patient Care Supplies

Catheter, indwelling, and nonlegend supplies
Decubitus Ulcer Care: pads, dressings, air mattresses, aquamatic K pads (water heated pads), alternating pressure pads, flotation pads and/or turning frames, heel protectors, donuts and sheepskins
Diabetic Blood and Urine Testing Supplies
Douche Bags
Drainage Sets, Bags, Tubes, etc.
Dressing Trays and Dressings (all types)
Enema Supplies
Gloves, nonsterile and sterile
Ice Bags
Incontinence Care, including pads, diapers and pants
Irrigation Trays and nonlegend supplies
Medicine Cups
Medicine Droppers

Appendix A

Needles, including but not limited to, hypodermic, scalp and vein

Nursing Services: regardless of level, administration of oxygen, restorative nursing care, nursing supplies, assistance with eating and massages provided by facility personnel

Nursing Supplies: lubricating jelly, betadine, benzoin, peroxide, A&D Ointment, tapes, alcohol, alcohol sponges, applicators, dressings and bandages (all types), cottonballs, tongue depressors and aerosol merthiolate

Ostomy supplies: adhesive, appliance, belts, face plates, flanges, gaskets, irrigation sets, night drains, protective dressings, skin barriers, tail closures and bags

Suture care, including trays and removal kits

Syringes, all sizes and types (including Ascepto)

Tape for laboratory tests

Urinary drainage tube and bottle

Therapeutic Agents and Supplies

Antacids, nonlegend

Drugs, stock (excluding insulin)

Enteral Feedings (including by tube) and all related supplies

IV Therapy Supplies: arm boards, needles, tubing and other related supplies

Laxatives, nonlegend

Oxygen, portable or stationary, oxygen delivery systems, concentrators and supplies

Special Diets

Stool Softeners, nonlegend

Vitamins, including minerals

(All covered supplies subject to changes in Federal and State Medicaid law)

Appendix B

Medicare:

Long-term care, whether received in a facility or in an individual's home, is considered *custodial care*, and provides help with activities of daily living such as bathing, dressing, using the bathroom and eating. Medicare does not cover long-term care or custodial care.

Medicare Part A (hospital insurance) does cover *skilled care* given in a certified skilled nursing facility or in your individual home. You may be entitled to limited skilled nursing facility coverage after a three (3) day stay in the hospital, not counting the day you are discharged. This benefit includes semi-private room charges, meals, skilled nursing and rehabilitative services, prescription medication, and other services and supplies.

For each benefit period, YOU PAY:

- Nothing for the first 20 days;
- Up to \$148.00* per day for days 21-100; and
- All costs beyond the 100th day in the benefit period.

* Co-pay amounts may change each year – this amount is based on 2013 rates.

It is important to remember that Medicare coverage for long-term care is limited to those residents requiring a high level of care.

If you have questions about skilled nursing facility care and conditions of coverage, call **1-800-MEDICARE (1-800-633-4227)** or check out www.medicare.gov and click on the link for 'Facilities and Doctors.' Click on 'Compare Nursing Homes' for information about various long-term care facilities.

Medicaid:

Medicaid (MO HealthNet) will pay for care in a long-term care facility when the individual is unable to pay all of the cost and meets eligibility guidelines. Payment includes room and board, prescriptions, and medical care needs (see Appendix A for more information on covered services).

To be eligible for Medicaid benefits, you must be in a Medicaid vendor bed, meet the medical level of care criteria, and require help with bathing, walking, eating, and other daily activities. You cannot have cash assets of more than \$999.99, but your home is not counted as an asset. Any other property you own would be considered an available resource.

If you think you meet the requirements for Medicaid benefits, you should contact your county Family Support Division (FSD) Office to request an application. FSD staff or facility staff may help you fill out the necessary forms to determine if you are eligible for Medicaid benefits in a long-term care facility.

Appendix B

Once you move into a facility, your social security check and other monthly income must be used first to pay for your care, and Medicaid will pay the remainder. You will be able to keep \$40 per month (as of 1/1/2013) as a Personal Needs Allowance to use for whatever you want or need.

You can ask facility staff to help you contact your local FSD office.

Medicaid for Married Couples:

If your spouse is in a long-term care facility, you may be eligible for a 'division of assets' through the Medicaid program. The Family Support Division (FSD) Office will divide your assets so that you do not have to spend all of your savings on long-term care. Your spouse who lives in the community may also be eligible to keep part of your income to help maintain the home and pay for living expenses.

If you have any questions about division of assets, contact your local FSD Office.

Appendix C

Legal Issues

Below are simplified definitions. If you need more information regarding these topics, contact your local attorney or your local Legal Services Office.

Guardianship/Conservatorship:

A guardian or conservator is appointed through a court hearing. A guardian handles the care of the person, such as making sure the person has adequate food, clothing, shelter, and medical care. A conservator handles the financial matters of the individual. A physician who has examined the person must answer written questions and provide the court with an opinion about whether the person needs a guardian or conservator. A long-term care facility cannot require you to have a guardian or conservator.

Durable Powers of Attorney (DPOA)

A Durable Power of Attorney enables the person creating it to appoint the persons they want to make decisions for them.

- ❖ A DPOA for **Health Care** allows the appointed person to make health care decisions when the individual becomes unable to do so.
- ❖ A DPOA for **General (Financial) Matters** allows the appointed person to make financial decisions when the individual can no longer handle their financial affairs.
- ❖ DPOA documents contain only the powers that the individual specifies.
- ❖ Durable means the document is valid even if the individual becomes unable to make their own decision.

A Durable Power of Attorney can only be given with your approval and must be signed when you are competent. You can withdraw the document any time you wish. A Power of Attorney that does NOT say “durable” is *only valid* when you are competent.

A DPOA for Health Care does not allow the appointee to make any other decisions for you. It is *only valid* when one or two physicians certify that you are unable to make your own decisions.

Representative Payee:

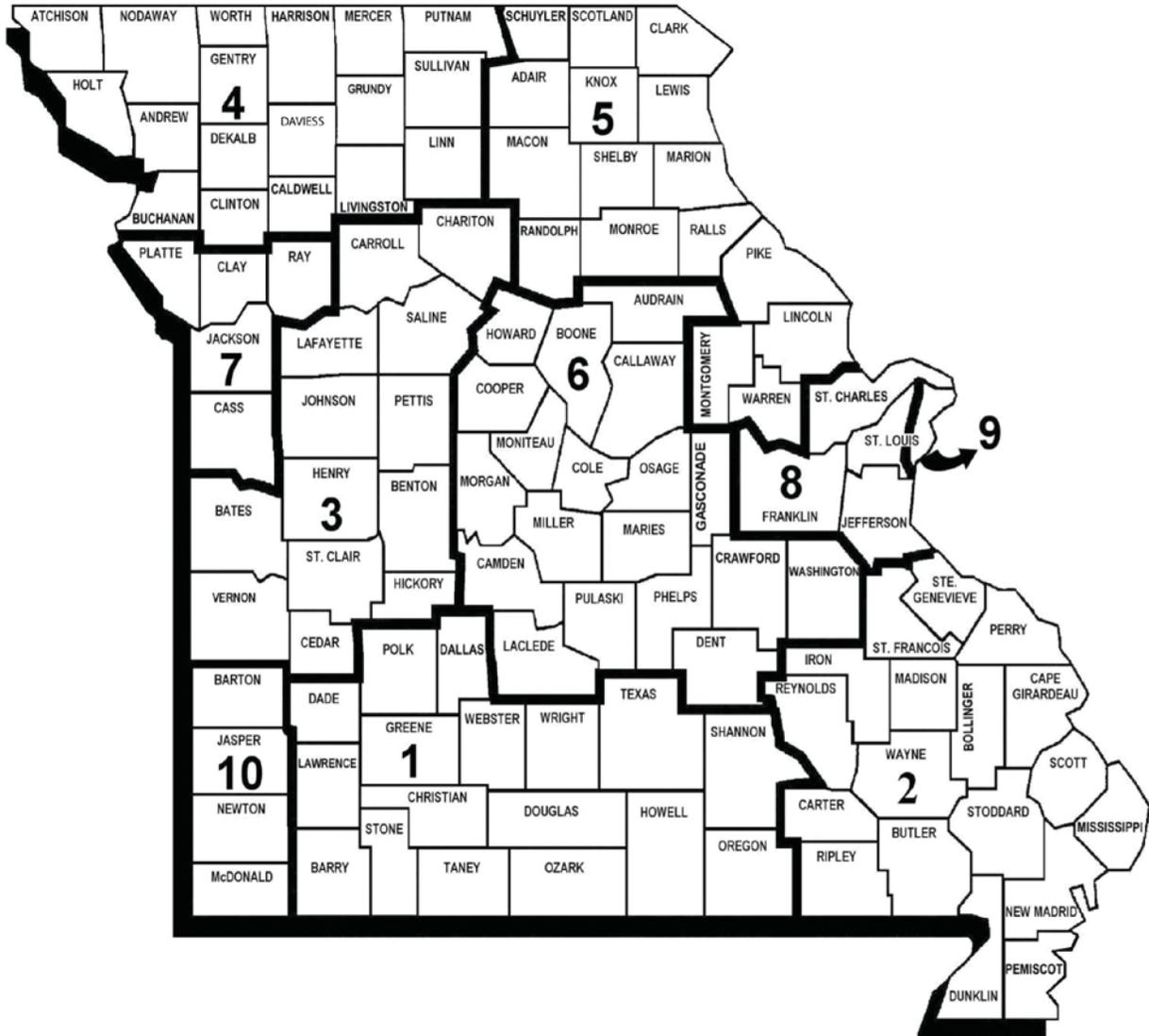
A Representative Payee is a person or entity designated by the Social Security Administration to receive and handle your monthly benefit checks. A Representative Payee may only use the funds for the recipient’s benefit and does not have the right to handle any other finances for the recipient, unless appointed by another legal authority.

Appendix D

Acronyms

AAA	Area Agency on Aging	HMO	Health Maintenance Organization
ADA	Americans with Disabilities Act		
ADC	Adult Day Care		
ALF	Assisted Living Facility	I & A	Information and Assistance
AoA	Administration on Aging	ICF	Intermediate Care Facility
APS	Adult Protective Services		
		LOC	Level of Care
CFR	Code of Federal Regulations	LPN	Licensed Practical Nurse
CMS	Centers for Medicare and Medicaid Services	LTC	Long-term Care
		LTCOP	Long-term Care Ombudsman Program
CMT	Certified Medical Technician		
CNA	Certified Nurse Assistant		
CPR	Cardiopulmonary Resuscitation	MDS	Minimum Data Set
CRU	Central Registry Unit	MHD	MO HealthNet Division
CSR	Code of State Regulation		
		OAA	Older Americans Act
DCPH	Division of Community and Public Health	OBRA	Omnibus Budget Reconciliation Act
DD	Developmental Disabilities	OSHA	Occupational Safety and Health Administration
DHSS	Department of Health and Senior Services		
		QA	Quality Assurance
DRL	Division of Regulation and Licensure		
		PS	Protective Services
DSDS	Division of Senior and Disability Services		
		RAP	Resident Assessment Protocol
DMH	Department of Mental Health	RCF	Residential Care Facility
DON	Director of Nursing	RN	Registered Nurse
DSS	Department of Social Services	ROM	Range of Motion
		RUG	Resource Utilization Group
FSD	Family Support Division		
		SLTC	Section for Long-Term Care Regulations
HCBS	Home and Community Based Services		
		SNF	Skilled Nursing Facility
HHA	Home Health Agency	SOD	Statement of Deficiencies
HHS	US Department of Health and Human Services	SSA	Social Security Administration
		SSI	Supplemental Security Income

Missouri Long-Term Care Ombudsman Program



Office of the State Long-Term Care Ombudsman
Department of Health and Senior Services
PO Box 570
Jefferson City MO 65102

1-800-309-3282

REGIONAL OMBUDSMAN OFFICES

- 1/10 Council of Churches of the Ozarks**
PO Box 3947
Springfield MO 65808
417.862.3598 / FAX 417.862.2129
www.ccozarks.org
- 2. Southeast MO Area Agency on Aging**
1219 N Kingshighway Suite 100
Cape Girardeau MO 63701
800.392.8771 / FAX 573.335.3017
www.semoaaa.org
- 3. Care Connection for Aging Services**
PO Box 1078
Warrensburg MO 64093
800.748.7826 / FAX 660.747.3100
www.goaging.org
- 4. Northwest MO Area Agency on Aging**
1304 N Walnut, PO Box 185
Cameron MO 64429
888.844.5626 / FAX 816.749.0034
www.nwmoaaa.org
- 5. VOYCE / Northeast MO**
8702 Manchester Rd
Brentwood MO 63144
866.918.8222 / FAX 314.918.9188
www.ltcop-stl.org
- 6. Central MO Area Agency on Aging**
1121 Business Loop 70 East, Ste 2A
Columbia MO 65201
573.443.5823 / FAX 573.875.8907
www.cmaaa.net
- 7. Mid-America Regional Council**
600 Broadway, Suite 200
Kansas City MO 64105-1536
816.474.4240 / FAX 816.421.7758
www.marc.org
- 8/9 VOYCE**
8702 Manchester Rd
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www.ltcop-stl.org

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For additional copies, more information, or to request help from
an Ombudsman, please contact:

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Department of Health and Senior Services
P.O. Box 570
Jefferson City MO 65102-0570

1-800-309-3282

E-mail: LTCOmbudsman@health.mo.gov
www.health.mo.gov/seniors/ombudsman

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Alternate forms of this publication for persons with disabilities may be obtained by
contacting the Missouri Department of Health and Senior Services at 800-309-3282.
Hearing- and speech-impaired citizens can dial 711.

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

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