410 IAC 16.2-3.1-4 NOTICE OF RIGHTS AND SERVICES
Sec. 4

...(f) The facility must do the following:

(1) Inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or when the resident becomes eligible for Medicaid of the following:

(A) The items and services that are included in nursing facility services under the state plan and for which the resident may not be charged.

(B) Those other items and services that the facility offers and for which the resident may be charged and the amount of the charges.

(2) Inform each resident when changes are made to the items and services specified in this section.

(3) Inform each resident before, or at the time of admission, in writing 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 or by the facility’s per diem rate.

...(i) Residents have the right to be informed by the facility, in writing, at least thirty (30) days in advance of the effective date, of any changes in the rates or services that these rates cover.

...(l) The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information, about how to:

(1) apply for and use Medicare and Medicaid benefits; and

(2) receive refunds for previous payments covered by such benefits.

410 IAC 16.2-3.1-5 NOTIFICATION OF CHANGES
Sec. 5.

(a) A facility must immediately inform the resident, consult with the resident’s physician, and, if known, notify the resident’s legal representative or an interested family member when there is:
...(4) a decision to transfer or discharge the resident from the facility.

410 IAC 16.2-3.1-12 TRANSFER AND DISCHARGE RIGHTS

Sec. 12.

(a) The transfer and discharge rights of residents of a facility are as follows:
(1) As used in this section, “interfacility transfer and discharge” means the movement of a resident to a bed outside of the licensed facility. For Medicare and Medicaid certified facilities, an interfacility transfer and discharge means the movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not.
(2) As used in this section, “intrafacility transfer” means the movement of a resident to a bed within the same licensed facility. For Medicare and Medicaid certified facilities, an intrafacility transfer means the movement of a resident to a bed within the same certified facility.
(3) When a transfer or discharge of a resident is proposed, whether intrafacility or interfacility, provision for continuity of care shall be provided by the facility.
(4) Health facilities must permit each resident to remain in the facility and not transfer or discharge the resident from the facility unless:
(A) the transfer or discharge is necessary for the resident’s welfare and the resident’s needs cannot be met in the facility;
(B) the transfer or discharge is appropriate because the resident’s health has improved sufficiently so that the resident no longer needs the services provided by the facility;
(C) the safety of individuals in the facility is endangered;
(D) the health of individuals in the facility would otherwise be endangered;
(E) 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; or
(F) the facility ceases to operate.
(5) When the facility proposes to transfer or discharge a resident under any of the circumstances specified in subdivision (4)(A), (4)(B), (4)(C), (4)(D), or (4)(E), the resident’s clinical records must be documented. The documentation must be made by the following:

(A) The resident’s physician when transfer or discharge is necessary under subdivision (4)(A) or (4)(B).

(B) Any physician when transfer or discharge is necessary under subdivision (4)(D).

(6) Before an interfacility transfer or discharge occurs, the facility must, on a form prescribed by the department, do the following:

(A) Notify the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner that the resident understands. The health facility must place a copy of the notice in the resident’s clinical record and transmit a copy to the following:

(i) The resident.

(ii) A family member of the resident if known.

(iii) The resident’s legal representative if known.

(iv) The local long term care ombudsman program (for involuntary relocations or discharges only).

(v) The person or agency responsible for the resident’s placement, maintenance, and care in the facility.

(vi) In situations where the resident is developmentally disabled, the regional office of the division of disability, aging, and rehabilitative services, who may assist with placement decisions.

(vii) The resident’s physician when the transfer or discharge is necessary under subdivision (4)(C), (4)(D), (4)(E), or (4)(F).

(B) Record the reasons in the resident’s clinical record.
(C) Include in the notice the items described in subdivision (9).

(7) Except when specified in subdivision (8), the notice of transfer or discharge required under subdivision (6) must be made by the facility at least thirty (30) days before the resident is transferred or discharged.

(8) Notice may be made as soon as practicable before transfer or discharge when:

(A) the safety of individuals in the facility would be endangered;

(B) the health of individuals in the facility would be endangered;

(C) the resident’s health improves sufficiently to allow a more immediate transfer or discharge;

(D) an immediate transfer or discharge is required by the resident’s urgent medical needs;

or

(E) a resident has not resided in the facility for thirty (30) days.

(9) For health facilities, the written notice specified in subdivision (7) must include the following:

(A) The reason for transfer or discharge.

(B) The effective date of transfer or discharge.

(C) The location to which the resident is transferred or discharged.

(D) A statement in not smaller than 12-point bold type that reads, “You have the right to appeal the health facility’s decision to transfer you. If you think you should not have to leave this facility, you may file a written request for a hearing with the Indiana state department of health postmarked within ten (10) days after you receive this notice. If you request a hearing, it will be held within twenty-three (23) days after you receive this notice, and you will not be transferred from the facility earlier than thirty-four (34) days after you receive this notice of transfer or discharge unless the facility is authorized to transfer you under subdivision (8). If you wish to appeal this transfer or discharge, a form to appeal the health facility’s decision and to request a hearing is attached. If you have
any questions, call the Indiana state department of health at the number listed below.

(E) The name of the director, address, telephone number, and hours of operation of the division.

(F) A hearing request form prescribed by the department.

(G) The name, address, and telephone number of the division and local long term care ombudsman.

(H) For facility residents with developmental disabilities or who are mentally ill, the mailing address and telephone number of the protection and advocacy services commission.

(10) If the resident appeals the transfer or discharge, the facility may not transfer or discharge the resident within thirty-four (34) days after the resident receives the initial transfer or discharge notice, unless an emergency exists as provided under subdivision (8).

(11) If nonpayment is the basis of a transfer or discharge, the resident shall have the right to pay the balance owed to the facility up to the date of the transfer or discharge and then is entitled to remain in the facility.

(12) The department shall provide a resident who wishes to appeal the transfer or discharge from a facility the opportunity to file a request for a hearing postmarked within ten (10) days following the resident’s receipt of the written notice of the transfer or discharge from the facility.

(13) If a facility resident requests a hearing, the department shall hold an informal hearing at the facility within twenty-three (23) days from the date the resident receives the notice of transfer or discharge. The department shall attempt to give at least five (5) days written notice to all parties prior to the informal hearing. The department shall issue a decision within thirty (30) days from the date the resident receives the notice. The facility must convince the department by a preponderance of the evidence that the transfer or discharge is authorized under subdivision (4). If the department determines that the transfer is appropriate, the resident must not be required to leave the facility within the thirty-four (34) days after the resident’s receipt of the initial transfer or discharge notice unless an emergency exists.
under subdivision (8). Both the resident and the facility have the right to administrative or judicial review under IC 4-21.5 of any decision or action by the department arising under this section. If a hearing is to be held de novo, that hearing shall be held in the facility where the resident resides.

...(18) Prior to any interfacility or involuntary intrafacility relocation, the facility shall prepare a relocation plan to prepare the resident for relocation and to provide continuity of care. In non-emergency relocations, the planning process shall include relocation planning conference to which the resident, his or her legal representative, family members, and physician shall be invited. The planning conference may be waived by the resident or his or her legal representative.

(19) At the planning conference, the resident’s medical, psychosocial, and social needs with respect to the relocation shall be considered and a plan devised to meet these needs.

(20) The facility shall provide reasonable assistance to the resident to carry out the relocation plan.

(21) The facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

(22) If the relocation plan is disputed, a meeting shall be held prior to the relocation with the administrator or his or her designee, the resident, and the resident’s legal representative. An interested family member, if known, shall be invited. The purpose of the meeting shall be to discuss possible alternatives to the proposed relocation plan.

(23) A written report of the content of the discussion at the meeting and the results of the meeting shall be reviewed by the administrator or his or her designee, the resident, the resident’s legal representative, and an interested family member, if known, each of whom may make written comments on the report.

(24) The written report of the meeting shall be included in the resident’s permanent record.
(25) Before a facility transfers a resident to a hospital or allows a resident to go on therapeutic leave of twenty-four (24) hours duration or longer, the facility must provide written information to the resident and a family member or legal representative that specifies the following:

(A) The duration of the bed‐hold policy under the Medicaid state plan during which the resident is permitted to return and resume residence in the facility.

(B) The facility's policies regarding bed‐hold periods, which must be consistent with subdivision (27), permitting a resident to return.

(26) Except in an emergency, at the time of transfer of a resident for hospitalization or therapeutic leave, a facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed‐hold policy described in subdivision (25).

(27) Medicaid certified facilities must establish and follow a written policy under which a resident, whose hospitalization or therapeutic leave exceeds the bed‐hold period under the state plan, is readmitted to the facility immediately upon the first availability of a bed in a semiprivate room if the resident:

(A) requires the services provided by the facility; and

(B) is eligible for Medicaid nursing facility services.

410 IAC 16.2-3.1-15 EQUAL ACCESS TO QUALITY CARE
Sec. 15.

(a) A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the state plan for all individuals regardless of source of payment.

(b) The facility may charge any amount for services furnished to non-Medicaid residents consistent with the notice requirement in section 4(f) of this rule describing the charges.

410 IAC 16.2-3.1-16 ADMISSIONS POLICY
Sec. 16.
(a) The facility must not:

(1) require residents or potential residents to waive their rights to Medicare or Medicaid; or

(2) require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits.

(b) The facility must not require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may require an individual 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.

(c) 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, or donation, or other consideration as a precondition of admission, expedited admission, or continued stay in the facility. However, a nursing facility may:

(1) 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; or

(2) solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a 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.