§483.10 Resident Rights
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 protect and promote the rights of each resident, including each of the following rights

Interpretive Guidelines §483.10
All residents in long term care facilities have rights guaranteed to them under Federal and State law. Requirements concerning resident rights are specified in §§483.10, 483.12, 483.13, and 483.15. Section 483.10 is intended to lay the foundation for the remaining resident’s rights requirements which cover more specific areas. These rights include the resident’s right to:

- Exercise his or her rights (§483.10(a));
- Be informed about what rights and responsibilities he or she has (§483.10(b));
- If he or she wishes, have the facility manage his personal funds (§483.10(c));
- Choose a physician and treatment and participate in decisions and care planning (§483.10(d));
- Privacy and confidentiality (§483.10(e));
- Voice grievances and have the facility respond to those grievances (§483.10(f));
- Examine survey results (§483.10(g));
- Work or not work (§483.10(h));
- Privacy in sending and receiving mail (§483.10(i));
- Visit and be visited by others from outside the facility (§483.10(j));
- Use a telephone in privacy (§483.10(k));
- Retain and use personal possessions (§483.10(l)) to the maximum extent that space and safety permit;
- Share a room with a spouse, if that is mutually agreeable (§483.10(m));
- Self-administer medication, if the interdisciplinary care planning team determines it is safe (§483.10(n)); and
- Refuse a transfer from a distinct part, within the institution (§483.10(o)).

A facility must promote the exercise of rights for each resident, including any who face barriers (such as communication problems, hearing problems and cognition limits) in the exercise of these rights. A resident, even though determined to be incompetent, should be able to assert these rights based on his or her degree of capability.

F151
§483.10(a) Exercise of Rights

§483.10(a)(1) 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.

§483.10(a)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights.

Interpretive Guidelines §483.10(a)(1)
Exercising rights means that residents have autonomy and choice, to the maximum extent possible, about how they wish to live their everyday lives and receive care, subject to the facility’s rules, as long as those rules do not violate a regulatory requirement.
**Intent §483.10(a)(2)**
This regulation is intended to protect each resident in the exercise of his or her rights.

**Interpretive Guidelines §483.10(a)(2)**
The facility must not hamper, compel, treat differentially, or retaliate against a resident for exercising his/her rights. Facility behaviors designed to support and encourage resident participation in meeting care planning goals as documented in the resident assessment and care plan are not interference or coercion. Examples of facility practices that may limit autonomy or choice in exercising rights include reducing the group activity time of a resident trying to organize a residents’ group; requiring residents to seek prior approval to distribute information about the facility; discouraging a resident from hanging a religious ornament above his or her bed; singling out residents for prejudicial treatment such as isolating residents in activities; or purposefully assigning inexperienced aides to a resident with heavy care needs because the resident and/or his/her representative, exercised his/her rights.

**Procedures §483.10(a)(2)**
Pay close attention to resident or staff remarks and staff behavior that may represent deliberate actions to promote or to limit a resident’s autonomy or choice, particularly in ways that affect independent functioning. Because reprisals may indicate abuse, if the team determines that a facility has violated this requirement through reprisals taken against residents, then further determine if the facility has an effective system to prevent the neglect and abuse of residents. (§483.13(c), F224-F225.)

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**§483.10(a)(3) -- 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 are exercised by the person appointed under State law to act on the resident’s behalf.**

**§483.10(a)(4) -- In the case of a resident who has not been adjudged incompetent by the State court, any legal-surrogate designated in accordance with State law may exercise the resident’s rights to the extent provided by State law.**

**Interpretive Guidelines §483.10(a)(3) and (4)**
When reference is made to “resident” in the Guidelines, it also refers to any person who may, under State law, act on the resident’s behalf when the resident is unable to act for himself or herself. That person is referred to as the resident’s surrogate or representative. If the resident has been formally declared incompetent by a court, the surrogate or representative is whoever was appointed by the court - a guardian, conservator, or committee. The facility should verify that a surrogate or representative has the necessary authority. For example, a court-appointed conservator might have the power to make financial decisions, but not health care decisions. A resident may wish to delegate decision-making to specific persons, or the resident and family may have agreed among themselves on a decision-making process. To the degree permitted by
State law, and to the maximum extent practicable, the facility must respect the resident’s wishes and follow that process.
The rights of the resident that may be exercised by the surrogate or representative include the right to make health care decisions. However, the facility may seek a health care decision (or any other decision or authorization) from a surrogate or representative only when the resident is unable to make the decision. If there is a question as to whether the resident is able to make a health care decision, staff should discuss the matter with the resident at a suitable time and judge how well the resident understands the information. In the case of a resident who has been formally declared incompetent by a court, lack of capacity is presumed. Notwithstanding the above, if such a resident can understand the situation and express a preference, the resident should be informed and his/her wishes respected to the degree practicable. Any violations with respect to the resident’s exercise of rights should be cited under the applicable tag number.
The involvement of a surrogate or representative does not automatically relieve a facility of its duty to protect and promote the resident’s interests. For example, a surrogate or representative does not have the right to insist that a treatment be performed that is not medically appropriate, and the right of a surrogate or representative to reject treatment may be subject to State law limits.

Procedures §483.10(a)(3) and (4)
Determine as appropriate if the rights of a resident who has been adjudged incompetent or who has a representative acting on his/her behalf to help exercise his/her rights are exercised by the legally appointed individual.

F153

§483.10(b)(2) -- The resident or his or her legal representative has the right--

(i) Upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays); and

(ii) After receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and 2 working days advance notice to the facility.

Interpretive Guidelines §483.10(b)(2)
An oral request is sufficient to produce the current record for review.
In addition to clinical records, the term “records” includes all records pertaining to the resident, such as trust fund ledgers pertinent to the resident and contracts between the resident and the facility.
“Purchase” is defined as a charge to the resident for photocopying. If State statute has defined the “community standard” rate, facilities should follow that rate. In the absence of State statute, the “cost not to exceed the community standard” is that rate charged per copy by organizations such as the public library, the Post Office or a commercial copy center, which would be selected by a prudent buyer in addition to the cost of the clerical time needed to photocopy the records. Additional fees for locating the records or typing forms/envelopes may not be assessed.
§483.10(b)(3) -- The resident has 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;

Interpretive Guidelines §483.10(b)(3)

“Total health status” includes functional status, medical care, nursing care, nutritional status, rehabilitation and restorative potential, activities potential, cognitive status, oral health status, psychosocial status, and sensory and physical impairments. Information on health status must be presented in language that the resident can understand. This includes minimizing use of technical jargon in communicating with the resident, having the ability to communicate in a foreign language and the use of sign language or other aids, as necessary. (See §483.10(d)(3), F175, for the right of the resident to plan care and treatment.)

Procedures §483.10(b)(3)

Look, particularly during observations and record reviews, for on-going efforts on the part of facility staff to keep residents informed. Look for evidence that information is communicated in a manner that is understandable to residents and communicated at times it could be most useful to residents, such as when they are expressing concerns, or raising questions, as well as on an on-going basis.

§483.10(d)(2) – The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident’s well-being;

Interpretive Guidelines §483.10(d)(2)

“Informed in advance” means that the resident receives information necessary to make a health care decision, including information about his/her medical condition and changes in medical condition, about the benefits and reasonable risks of the treatment, and about reasonable available alternatives.

§483.10(b)(4) -- The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section; and

Interpretive Guidelines §483.10(b)(4)

“Treatment” is defined as care provided for purposes of maintaining/restoring health, improving functional level, or relieving symptoms.

“Experimental research” is defined as development and testing of clinical treatments, such as an investigational drug or therapy, that involve treatment and/or control groups. For example, a clinical trial of an investigational drug would be experimental research.
“Advance directive” means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law relating to the provision of health care when the individual is incapacitated.

As provided under State law, a resident who has the capacity to make a health care decision and who withholds consent to treatment or makes an explicit refusal of treatment either directly or through an advance directive, may not be treated against his/her wishes.

A facility may not transfer or discharge a resident for refusing treatment unless the criteria for transfer or discharge are met. (See §483.12(a)(1) and (2).)

If the resident is unable to make a health care decision, a decision by the resident’s surrogate or representative to forego treatment may, subject to State law, be equally binding on the facility. The facility should determine exactly what the resident is refusing and why. To the extent the facility is able, it should address the resident’s concern. For example, a resident requires physical therapy to learn to walk again after sustaining a fractured hip. The resident refuses therapy. The facility is expected to assess the reasons for this resident’s refusal, clarify and educate the resident as to the consequences of refusal, offer alternative treatments, and continue to provide all other services.

If a resident’s refusal of treatment brings about a significant change, the facility should reassess the resident and institute care planning changes. A resident’s refusal of treatment does not absolve a facility from providing a resident with care that allows him/her to attain or maintain his/her highest practicable physical, mental and psychosocial well-being in the context of making that refusal.

The resident has the right to refuse to participate in experimental research. A resident being considered for participation in experimental research must be fully informed of the nature of the experiment (e.g., medication, treatment) and understand the possible consequences of participating. The opportunity to refuse to participate in experimental research must occur prior to the start of the research. Aggregated resident statistics that do not identify individual residents may be used for studies without obtaining residents’ permission.

**Procedures §483.10(b)(4)**

If the facility participates in any experimental research involving residents, does it have an Institutional Review Board or other committee that reviews and approves research protocols? In this regard, §483.75(c), Relationship to Other HHS Regulations applies (i.e., the facility must adhere to 45 CFR Part 46, Protection of Human Subjects of Research). See §483.10(b)(8), F156 with respect to the advance directive requirement.

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**§483.10(b)(1) -- 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 notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident’s stay. Receipt of such information, and any amendments to it, must be acknowledged in writing;**
Intent §483.10(b)(1)
This requirement is intended to assure that each resident know his or her rights and responsibilities and that the facility communicates this information prior to or upon admission, as appropriate during the resident’s stay, and when the facility’s rules change.

Interpretive Guidelines §483.10(b)(1)
“In a language that the resident understands” is defined as communication of information concerning rights and responsibilities that is clear and understandable to each resident, to the extent possible considering impediments which may be created by the resident’s health and mental status. If the resident’s knowledge of English or the predominant language of the facility is inadequate for comprehension, a means to communicate the information concerning rights and responsibilities in a language familiar to the resident must be available and implemented. For foreign languages commonly encountered in the facility locale, the facility should have written translations of its statements of rights and responsibilities, and should make the services of an interpreter available. In the case of less commonly encountered foreign languages, however, a representative of the resident may sign that he or she has explained the statement of rights to the resident prior to his/her acknowledgement of receipt. For hearing impaired residents who communicate by signing, the facility is expected to provide an interpreter. Large print texts of the facility’s statement of resident rights and responsibilities should also be available.

“Both orally and in writing” means if a resident can read and understand written materials without assistance, an oral summary, along with the written document, is acceptable.

Any time State or Federal laws relating to resident rights or facility rules change during the resident’s stay in the facility, he/she must promptly be informed of these changes.

“All rules and regulations” relates to facility policies governing resident conduct. A facility cannot reasonably expect a resident to abide by rules he or she has never been told about. Whatever rules the facility has formalized, and by which it expects residents to abide, should be included in the statement of rights and responsibilities.

§483.10(b)(5) -- The facility must--

(i) 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--

(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 charges for those services; and

(ii) Inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

§483.10(b)(6) -- 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 or by the facility’s per diem rate.
Interpretive Guidelines §483.10(b)(5) and (6)
Residents should be told in advance when changes will occur in their bills. Providers must fully inform the resident of services and related changes.
“Periodically” means that whenever changes are being introduced that will affect the residents liability and whenever there are changes in services.
A Medicare beneficiary who requires services upon admission that are not covered under Medicare may be required to submit a deposit provided the notice provisions of §483.10(b)(6), if applicable, are met.

Procedures §483.10(b)(5) and (6)
See §483.10(c)(8) for those items and services that must be included in payment under skilled nursing and nursing facility benefits.

§483.10(b)(7) -- The facility must furnish a written description of legal rights which includes--

(i) A description of the manner of protecting personal funds, under paragraph (c) of this section;

(ii) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple’s non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse’s medical care in his or her process of spending down to Medicaid eligibility levels;

(iii) A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and

(iv) A statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility; and non-compliance with the advance directives requirements.

Interpretive Guidelines §483.10(b)(7)
“The protection and advocacy network” refers to the system established to protect and advocate the rights of individuals with developmental disabilities specified in the Developmental Disabilities Assistance and Bill of Rights Act, and the protection and advocacy system established under the Protection and Advocacy for Mentally Ill Individuals Act.

Procedures §483.10(b)(7)
At the Entrance Conference, request a copy of the written information that is provided to residents regarding their rights and review it to determine if it addresses the specified
requirements. Additional requirements that address the implementation of these rights are cross-referenced below.

§483.10(b)(8) -- The facility must comply with the requirements specified in subpart I of part 489 of this chapter relating to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual’s option, formulate an advance directive. This includes a written description of the facility’s policies to implement advance directives and applicable State law

Interpretive Guidelines §483.10(b)(8)
This provision applies to residents admitted on or after December 1, 1991. 42 CFR 489.102 specifies that at the time of admission of an adult resident, the facility must:

• Provide written information concerning his/her rights under State law (whether or not statutory or recognized by the courts of the State) to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives;

• Document in the resident’s medical record whether or not the individual has executed an advance directive;

• Not condition the provision of care or discriminate against an individual based on whether or not the individual has executed an advance directive;

• Ensure compliance with requirements of State law regarding advance directives;

• Provide for educating staff regarding the facility’s policies and procedures on advance directives; and

• Provide for community education regarding the right under State law (whether or not recognized by the courts of the State) to formulate an advance directive and the facility’s written policies and procedures regarding the implementation of these rights, including any limitations the facility may have with respect to implementing this right on the basis of conscience. The facility is not required to provide care that conflicts with an advance directive. In addition, the facility is not required to implement an advance directive if, as a matter of conscience, the provider cannot implement an advance directive and State law allows the provider to conscientiously object. (See §483.10(b)(4), F155.)

The sum total of the community education efforts must include a summary of the State law, the rights of residents to formulate advance directives, and the facility’s implementation policies regarding advance directives. Video and audio tapes may be used in conducting the community education effort. Individual education programs do not have to address all the requirements if it would be inappropriate for a particular audience.
Procedures §483.10(b)(8)
During Resident Review, review the records of two selected sampled residents admitted on or after December 1, 1991, for facility compliance with advance directive notice requirements.
• Determine to what extent the facility educates its staff regarding advance directives.
• Determine to what extent the facility provides education for the community regarding one’s rights under State law to formulate advance directives.

§483.10(b)(9) -- The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

Interpretive Guidelines §483.10(b)(9)
“Physician responsible for his or her care” is defined as the attending or primary physician or clinic, whichever is responsible for managing the resident’s medical care, and excludes other physicians whom the resident may see from time to time. When a resident has selected an attending physician, it is appropriate for the facility to confirm that choice when complying with this requirement. When a resident has no attending physician, it is appropriate for the facility to assist residents to obtain one in consultation with the resident and subject to the resident’s right to choose. (See §483.10(d)(1), F163.) If a facility uses the services of a clinic or similar arrangement, it may be sufficient for residents to have the name and contact information for the primary physician and/or a central number for the clinic itself.

§483.10(b)(10) -- 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 apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

Interpretive Guidelines §483.10(b)(10)
To fulfill this requirement, the facility may use written materials issued by the State Medicaid agency and the Federal government relating to these benefits. Facilities may fulfill their obligation to orally inform residents or applicants for admission about how to apply for Medicaid or Medicare by assisting them in contacting the local Social Security Office or the local unit of the State Medicaid agency. Nursing facilities are not responsible for orally providing detailed information about Medicare and Medicaid eligibility rules. “Refunds for previous payments” refers to refunds due as a result of Medicaid and Medicare payments when eligibility has been determined retroactively.
As part of determining Medicaid eligibility, at the time of admission, a married couple has the right to request and have the appropriate State agency assess the couple’s resources.

F157

§483.10(b)(11) -- Notification of changes.
(i) 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--

(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;

(B) A significant change in the resident’s physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);

(C) A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or

(D) A decision to transfer or discharge the resident from the facility as specified in §483.12(a).

(ii) The facility must also promptly notify the resident and, if known, the resident’s legal representative or interested family member when there is--

(A) A change in room or roommate assignment as specified in §483.15(e)(2); or

(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

(iii) The facility must record and periodically update the address and phone number of the resident’s legal representative or interested family member.

Interpretive Guidelines §483.10(b)(11)
For purposes of §483.10(b)(11)(i)(B), life-threatening conditions are such things as a heart attack or stroke. Clinical complications are such things as development of a stage II pressure sore, onset or recurrent periods of delirium, recurrent urinary tract infection, or onset of depression. A need to alter treatment “significantly” means a need to stop a form of treatment because of adverse consequences (e.g., an adverse drug reaction), or commence a new form of treatment to deal with a problem (e.g., the use of any medical procedure, or therapy that has not been used on that resident before).

In the case of a competent individual, the facility must still contact the resident’s physician and notify interested family members, if known. That is, a family that wishes to be informed would designate a member to receive calls. Even when a resident is mentally competent, such a designated family member should be notified of significant changes in the resident’s health status because the resident may not be able to notify them personally, especially in the case of sudden illness or accident.
The requirements at §483.10(b)(1) require the facility to inform the resident of his/her rights upon admission and during the resident’s stay. This includes the resident’s right to privacy (§483.10(e), F164). If, after being informed of the right to privacy, a resident specifies that he/she wishes to exercise this right and not notify family members in the event of a significant change as specified at this requirement, the facility should respect this request, which would obviate the need to notify the resident’s interested family member or legal representative, if known. If a resident specifies that he/she does not wish to exercise the right to privacy, then the facility is required to comply with the notice of change requirements.

In the case of a resident who is incapable of making decisions, the representative would make any decisions that have to be made, but the resident should still be told what is happening to him or her.

In the case of the death of a resident, the resident’s physician is to be notified immediately in accordance with State law.

The failure to provide notice of room changes could result in an avoidable decline in physical, mental, or psychosocial well-being.

§483.10(c) Protection of Resident Funds

F158

§483.10(c)(1) Protection of Resident Funds
The resident has the right to manage his or her financial affairs, and the facility may not require residents to deposit their personal funds with the facility.

F159

§483.10(c)(2) Management of Personal Funds
Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.

§483.10(c)(3) Deposit of Funds

(i) Funds in excess of $50. The facility must deposit any 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. (In pooled accounts, there must be a separate accounting for each resident’s share.)

(ii) Funds less than $50. The facility must maintain a resident’s personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund.
NOTE: The Social Security Amendments of 1994 amended §1819(c)(6)(B)(i) to raise the limit from $50.00 to $100.00 for the minimum amount of resident funds that facilities must entrust to an interest bearing account. This increase applies only to Medicare SNF residents. While a facility may continue to follow a minimum of $50.00, the regulations do not require it.

Interpretive Guidelines §483.10(c)(1) through (3)
This requirement is intended to assure that residents who have authorized the facility in writing to manage any personal funds have ready and reasonable access to those funds. If residents choose to have the facility manage their funds, the facility may not refuse to handle these funds, but is not responsible for knowing about assets not on deposit with it.

Placement of residents’ personal funds of less than $50.00 ($100.00 for Medicare residents) in an interest bearing account is permitted. Thus, a facility may place the total amount of a resident’s funds, including funds of $50.00 ($100.00 for Medicare residents) or less, into an interest-bearing account. The law and regulations are intended to assure that residents have access to $50.00 ($100.00 for Medicare residents) in cash within a reasonable period of time, when requested. Requests for less than $50.00 ($100.00 for Medicare residents) should be honored within the same day. Requests for $50.00 ($100.00 for Medicare residents) or more should be honored within three banking days. Although the facility need not maintain $50.00 ($100.00 for Medicare residents) per resident on its premises, it is expected to maintain amounts of petty cash on hand that may be required by residents.

If pooled accounts are used, interest must be prorated per individual on the basis of actual earnings or end-of quarter balance.

Residents should have access to petty cash on an ongoing basis and be able to arrange for access to larger funds.

“Hold, safeguard, manage and account for” means that the facility must act as fiduciary of the resident’s funds and report at least quarterly on the status of these funds in a clear and understandable manner. Managing the resident’s financial affairs includes money that an individual gives to the facility for the sake of providing a resident with a noncovered service (such as a permanent wave). It is expected that in these instances, the facility will provide a receipt to the gift giver and retain a copy.

“Interest bearing” means a rate of return equal to or above the passbook savings rate at local banking institutions in the area.

Although the requirements are silent about oral requests by residents to have a facility hold personal funds, under the provisions regarding personal property (§483.10(l)), and misappropriation of property (§483.13(c)), residents may make oral requests that the facility temporarily place their funds in a safe place, without authorizing the facility to manage those funds. The facility has the responsibility to implement written procedures to prevent the misappropriation of these funds.
If you determine potential problems with funds through interviews, follow-up using the following procedures as appropriate:

If the facility does not have written authorization to handle resident’s funds, but is holding funds for more than a few days, determine if the facility is managing these funds without written authorization. There must be written authorization for the facility to be in compliance with this requirement.

To assure that facilities are not using oral requests by residents as a way to avoid obtaining written authorization to hold, manage, safeguard and account for resident’s funds, make sure that:

- There is a written declaration by the resident that the funds are being held for no more than a few days by the facility at the resident’s request;

- These funds are not held for more than a few days; and

- The facility provides the resident a receipt for these funds and retains a copy for its records.

Review the administrative or business file and the bookkeeping accounts of residents selected for a comprehensive review who have authorized the facility to handle their personal funds.

- Are residents’ funds over $50.00 ($100.00 for Medicare residents) or, at the facility’s option, all resident funds, in an interest bearing account(s)?

- What procedure was followed when residents requested their funds?

- How long does it take for residents to receive: (a) petty cash allotments; (b) funds needing to be withdrawn from bank accounts?

- Were limits placed on amounts that could be withdrawn? If yes, was the reason based on resident care needs or facility convenience?

- Are funds records treated with privacy as required at F164?

NOTE: Banks may charge the resident a fee for handling their funds. Facilities may not charge residents for managing residents’ funds because the services are covered by Medicare or Medicaid.

If problems are identified, review also §483.10(b)(7), Tag F156. Monies due residents should be credited to their respective bank accounts within a few business days.

§483.10(c)(4) Accounting and Records
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.
(i) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

(ii) The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.

Interpretive Guidelines §483.10(c)(4)
This requirement constitutes the overall response of the facility to the resident’s right to have the facility manage the resident’s funds.

“Generally accepted accounting principles” means that the facility employs proper bookkeeping techniques, by which it can determine, upon request, the amount of individual resident funds and, in the case of an interest bearing account, how much interest these funds have earned for each resident, as last reported by the banking institution to the facility.

Proper bookkeeping techniques would include an individual ledger card, ledger sheet or equivalent established for each resident on which only those transactions involving his or her personal funds are recorded and maintained. The record should have information on when transactions occurred, what they were, as well as maintain the ongoing balance for every resident.

Anytime there is a transaction the resident should be given a receipt and the facility retains a copy.

Monies due residents should be credited to their respective bank accounts within a few business days.

“Quarterly statements” are to be provided in writing to the resident or the resident’s representative within 30 days after the end of the quarter.

§483.10(c)(5) Notice of Certain Balances
The facility must notify each resident that receives Medicaid benefits—

(i) When the amount in the resident’s account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and

(ii) That, 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.

Interpretive Guidelines §483.10(c)(5)
The Social Security District Office can provide you with information concerning current SSI resource limits.
Procedures §483.10(c)(5)
If problems are identified for sampled residents who are Medicaid recipients, review financial records to determine if their accounts are within $200.00 of the SSI limit. If there are sampled residents in this situation, ask them or their representatives if they have received notice.

F160
483.10(c)(6) Conveyance upon death
Upon the 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 individual or probate jurisdiction administering the resident’s estate.

Procedures §483.10(c)(6)
As part of closed records review, determine if within 30 days of death, the facility conveyed the deceased resident’s personal funds and a final accounting to the individual or probate jurisdiction administering the individual’s estate as provided by State law.

F161
483.10(c)(7) Assurance of Financial Security
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.

Interpretive Guidelines §483.10(c)(7)
A surety bond is an agreement between the principal (the facility), the surety (the insurance company), and the obligee (depending on State law, either the resident or the State acting on behalf of the resident), wherein the facility and the insurance company agree to compensate the resident (or the State on behalf of the resident) for any loss of residents’ funds that the facility holds, safeguards, manages, and accounts for.

The purpose of the surety bond is to guarantee that the facility will pay the resident (or the State on behalf of the resident) for losses occurring from any failure by the facility to hold, safeguard, manage, and account for the residents’ funds, i.e., losses occurring as a result of acts or errors of negligence, incompetence or dishonesty.

Unlike other types of insurance, the surety bond protects the obligee (the resident or the State), not the principal (the facility), from loss. The surety bond differs from a fidelity bond, which covers no acts or errors of negligence, incompetence or dishonesty.

The surety bond is the commitment of the facility in an objective manner to meet the standard of conduct specified in §483.10(c)(2), that the facility will hold, safeguard, manage and account for the funds residents have entrusted to the facility. The facility assumes the responsibility to compensate the obligee for the amount of the loss up to the entire amount of the surety bond.

Reasonable alternatives to a surety bond must:
• Designate the obligee (depending on State law, the resident individually or in aggregate, or the State on behalf of each resident) who can collect in case of a loss;

• Specify that the obligee may collect due to any failure by the facility, whether by commission, bankruptcy, or omission, to hold, safeguard, manage, and account for the residents’ funds; and

• Be managed by a third party unrelated in any way to the facility or its management. The facility cannot be named as a beneficiary.

Self-insurance is not an acceptable alternative to a surety bond. Likewise, funds deposited in bank accounts protected by the Federal Deposit Insurance Corporation, or similar entity, also are not acceptable alternatives.

Procedures §483.10(c)(7)
As part of Phase 2, if your team has any concerns about residents’ funds, check the amount of the surety bond to make sure it is at least equal to the total amount of residents’ funds, as of the most recent quarter.

If the State survey agency determines that individual circumstances associated with a facility’s surety bond or its alternative are such that the survey agency cannot determine whether or not the facility is in compliance with the requirements at §483.10(c)(7), then it would be appropriate to make the referral to the State’s fiscal department.

If a corporation has a surety bond that covers all of its facilities, there should be a separate review of the corporation’s surety bond by the appropriate State agency, such as the State’s fiscal department, to ensure that all the residents in the corporation’s facilities within the State are covered against any losses due to acts or errors by the corporation or any of its facilities. The focus of the review should be to ensure that if the corporation were to go bankrupt or otherwise cease to operate, the funds of the residents in the corporation’s facilities would be protected.

F162

§483.10(c)(8) Limitation on Charges to Personal Funds
The facility may not impose a charge against the personal funds of a resident for any item or services for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts).

The facility may charge the resident for requested services that are more expensive than or in excess of covered services in accordance with §489.32 of this chapter. (This does not affect the prohibition on facility charges for items and services for which Medicaid has paid. See §447.15, which limits participation in the Medicaid program to providers who accept, as payment in full, Medicaid payment plus any deductible, coinsurance, or copayment required by the plan to be paid by the individual.)
(i) Services included in Medicare or Medicaid payment. During the course of a covered Medicare or Medicaid stay, facilities may not charge a resident for the following categories of items and services:

(A) Nursing services as required at §483.30 of this subpart.

(B) Dietary services as required at §483.35 of this subpart.

(C) An activities program as required at §483.15(f) of this subpart.

(D) Room/bed maintenance services.

(E) 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 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, and basic personal laundry.

(F) Medically-related social services as required at §483.15(g) of this subpart.

(ii) Items and services that may be charged to residents’ funds. Listed below are general categories and examples of items and services that the facility may charge to residents’ funds if they are requested by a resident, if the facility informs the resident that there will be a charge, and if payment is not made by Medicare or Medicaid:

(A) Telephone;

(B) Television/radio for personal use;

(C) Personal comfort items, including smoking materials, notions and novelties, and confections;

(D) Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare;

(E) Personal clothing;

(F) Personal reading matter;

(G) Gifts purchased on behalf of a resident;

(H) Flowers and plants; and
(I) Social events and entertainment offered outside the scope of the activities program, provided under §483.15(f) of this subpart.

(J) Noncovered special care services such as privately hired nurses or aides.

(K) Private room, except when therapeutically required (for example, isolation for infection control).

(L) Specially prepared or alternative food requested instead of the food generally prepared by the facility, as required by §483.35 of this subpart.

Intent §483.10(c)(8)
The intent of this requirement is to specify that facilities not charge residents for items and services for which payment is made under Medicare or Medicaid.

Interpretive Guidelines §483.10(c)(8)
The facility may charge the resident the difference for requested services that are more expensive than or in excess of covered services in accordance with §489.32 of this chapter. (This does not affect the prohibition on facility charges for items and services for which Medicaid has paid. See §447.15, which limits participation in the Medicaid program to providers who accept, as payment in full, Medicaid payment plus any deductible, coinsurance, or co-payment required by the plan to be paid by the individual.) If a State plan does not cover an item or service, such as eyeglasses, the resident may purchase that item or service out of his/her funds. See §483.15(g), F250 for the facility’s responsibility to assist the resident in obtaining those services.

Procedures §483.10(c)(8)
As appropriate during Phase 2 of the survey, review the written information given to Medicare/Medicaid eligible residents and family members on admission that notifies them of the items and services that are covered under Medicare or the State plan. Review a sample of residents’ monthly statements to ensure that personal funds are not used to pay for covered services. If charges found on monthly statements indicate that residents may have paid for covered items or services, determine if these items or services are over and above what is paid by Medicare or Medicaid.

If, through observations or interviews of residents selected for comprehensive or focused review, the team determines that families or residents hire sitters, and/or that a large number of residents or families are paying for outside food, determine if these practices reflect inadequate staffing and/or food.

Interpretive Guidelines §483.10(c)(8)(i)(E)
Prescription drugs are part of the pharmaceutical services that facilities are required to provide. (See §483.25(l) and (m), and §483.60.) However, at times, a resident needs a medical service that is recognized by State law, but not covered by the State plan. Such a medical service includes a prescription drug that is not on the State’s formulary or that exceeds the number of medications covered by Medicaid. It may also include prescription eyeglasses or dentures. If a resident needs a recognized medical service over what is allowed by the State plan, the resident
has the right under the Medicaid statute to spend his/her income on that service. If the service is more than what Medicaid pays, the resident may deduct the actual cost of the service from the Medicaid share of the cost. The facility must assist the resident in exercising his or her right to the uncovered medical expense deduction and may not charge the resident for such services. “Hair hygiene supplies” refers to comb, brush, shampoos, trims and simple hair cuts provided by facility staff as part of routine grooming care. Hair cuts, permanent waves, hair coloring, and relaxing performed by barbers and beauticians not employed by a facility are chargeable. “Nail hygiene services” refers to routine trimming, cleaning, filing, but not polishing of undamaged nails, and on an individual basis, care for ingrown or damaged nails. “Basic personal laundry” does not include dry cleaning, mending, washing by hand, or other specialty services that need not be provided. A resident may be charged for these specialty services if he or she requests and receives them.

**Interpretive Guidelines §483.10(c)(8)(ii)(I) Social Events**

Facilities are required by §483.15(f) to provide an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and physical, mental, and psychosocial well-being of each resident, and cannot charge residents for these services, whether they occur at the facility or off-site. Resident funds should not be charged for universal items such as bookmobile services or local newspaper subscriptions intended for use by more than one resident. However, if a resident requests and attends a social event or entertainment that is not part of the activities assessment and care plan for that resident, a facility may charge that resident’s account only for actual expenses. Further, because of expenses associated with transportation, escorts and other related costs, a resident may be charged for actual expenses for an event or entertainment he or she requests and attends that may be free to the public.

**Interpretive Guidelines §483.10(c)(8)(ii)(L) Specially Prepared Foods**

A resident may refuse food usually prepared and food substitutions of similar nutritive value because of personal, religious, cultural, or ethnic preference. If the resident requests and receives food that is either not commonly purchased by the facility or easily prepared, then the facility may charge the resident. For example, the facility may charge the resident’s account for specially prepared food if the facility has a restricted diet policy and notified the resident on admission of the fact, in accordance with §483.10(b). The facility may not charge the resident’s account for specially prepared foods that are required by the physician’s order of a therapeutic diet. If a facility changes its menu so that the menu no longer reflects the food preferences of residents, see F165, F242, and F243 to determine compliance with these requirements.

(iii) Requests for items and services.

(A) The facility must not charge a resident (or his or her representative) for any item or service not requested by the resident.

(B) The facility must not require a resident (or his or her representative) to request any item or service as a condition of admission or continued stay.
(C) The facility must inform the resident (or his or her representative) 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.

Interpretive Guidelines §483.10(c)(8)(iii) Requests for Items and Services
A facility may not charge a resident or the resident’s representative for items and services that are not requested by the resident or representative, whether or not the item or services is requested by a physician. The item or service ordered by the physician should fit in with the resident’s care plan.

§483.10(d) Free Choice
The resident has the right to--

F163
§483.10(d)(1) -- Choose a personal attending physician

Interpretive Guidelines §483.10(d)(1)
The right to choose a personal physician does not mean that the physician must or will serve the resident, or that a resident must designate a personal physician. If a physician of the resident’s choosing fails to fulfill a given requirement, such as §483.25(l)(1), Unnecessary drugs; §483.25(l)(2), Antipsychotic drugs; or §483.40, frequency of physician visits, the facility will have the right, after informing the resident, to seek alternate physician participation to assure provision of appropriate and adequate care and treatment. A facility may not place barriers in the way of residents choosing their own physicians. For example, if a resident does not have a physician, or if the resident’s physician becomes unable or unwilling to continue providing care to the resident, the facility must assist the resident in exercising his or her choice in finding another physician.

Before consulting an alternate physician, one mechanism to alleviate a possible problem could involve the facility’s utilization of a peer review process for cases which cannot be satisfactorily resolved by discussion between the medical director and the attending physician. Only after a failed attempt to work with the attending physician or mediate differences in delivery of care should the facility request an alternate physician when requested to do so by the resident or when the physician will not adhere to the regulations.

If it is a condition for admission to a continuing care retirement center, the requirement for free choice is met if a resident is allowed to choose a personal physician from among those who have practice privileges at the retirement center.

A resident in a distinct part of a general acute care hospital can choose his/her own physician, unless the hospital requires that physicians with residents in the distinct part have hospital admitting privileges. If this is so, the resident can choose his/her own physician, but cannot have a physician who does not have hospital admitting privileges.

If residents appear to have problems in choosing physicians, determine how the facility makes physician services available to residents.
§483.10(e) Privacy and Confidentiality
The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.

(1) 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;

(2) Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility;

(3) The resident’s right to refuse release of personal and clinical records does not apply when--

(i) The resident is transferred to another health care institution; or

(ii) Record release is required by law

Interpretive Guidelines §483.10(e)
“Right to privacy” means that the resident has the right to privacy with whomever the resident wishes to be private and that this privacy should include full visual, and, to the extent desired, for visits or other activities, auditory privacy. Private space may be created flexibly and need not be dedicated solely for visitation purposes.

For example, privacy for visitation or meetings might be arranged by using a dining area between meals, a vacant chapel, office or room; or an activities area when activities are not in progress. Arrangements for private space could be accomplished through cooperation between the facility’s administration and resident or family groups so that private space is provided for those requesting it without infringement on the rights of other residents.

With the exception of the explicit requirement for privacy curtains in all initially certified facilities (see §483.70(d)(1)(v)), the facility is free to innovate to provide privacy for its residents, as exemplified in the preceding paragraph. This may, but need not, be through the provision of a private room.

Facility staff must examine and treat residents in a manner that maintains the privacy of their bodies. A resident must be granted privacy when going to the bathroom and in other activities of personal hygiene. If an individual requires assistance, authorized staff should respect the individual’s need for privacy. Only authorized staff directly involved in treatment should be present when treatments are given. People not involved in the care of the individual should not be present without the individual’s consent while he/she is being examined or treated. Staff should pull privacy curtains, close doors, or otherwise remove residents from public view and
provide clothing or draping to prevent unnecessary exposure of body parts during the provision of personal care and services.

Personal and clinical records include all types of records the facility might keep on a resident, whether they are medical, social, fund accounts, automated or other. Additional guidelines on mail, visitation rights and telephone communication are addressed in §483.10(i), (j) and (k). See §483.70(d)(1)(iv) for full visual privacy around beds.

**Procedures §483.10(e)(1) - (3)**

Document any instances where you observe a resident’s privacy being violated. Completely document how the resident’s privacy was violated (e.g., Resident #12 left without gown or bed covers and unattended), and where and when this occurred (e.g., 2B Corridor, 3:30 pm, February 25). If possible, identify the responsible party.

§483.75(l)(4) The facility must keep confidential all information contained in the resident’s records, regardless of the form or storage method of the records, except when release is required by--

(i) Transfer to another health care institution;

(ii) Law;

(iii) Third party payment contract; or

(iv) The resident.

**Interpretive Guidelines §483.75(l)(4)**

“Keep confidential” is defined as safeguarding the content of information including video, audio, or other computer stored information from unauthorized disclosure without the consent of the individual and/or the individual’s surrogate or representative.

If there is information considered too confidential to place in the record used by all staff, such as the family’s financial assets or sensitive medical data, it may be retained in a secure place in the facility, such as a locked cabinet in the administrator’s office. The record should show the location of this confidential information.

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§483.10(f) Grievances

A resident has the right to—

F165

A resident has the right to –
§483.10(f)(1) -- Voice grievances without discrimination or reprisal. Such grievances include those with respect to treatment which has been furnished as well as that which has not been furnished; and
(SEE TAG 166 FOR GUIDANCE)

F166
A resident has the right to--

§483.10(f)(2) -- Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

Intent §483.10(f)
The intent of the regulation is to support each resident’s right to voice grievances (e.g., those about treatment, care, management of funds, lost clothing, or violation of rights) and to assure that after receiving a complaint/grievance, the facility actively seeks a resolution and keeps the resident appropriately apprised of its progress toward resolution

Interpretive Guidelines §483.10(f)
“Voice grievances” is not limited to a formal, written grievance process but may include a resident’s verbalized complaint to facility staff.
“Prompt efforts...to resolve” include facility acknowledgment of complaint/grievances and actively working toward resolution of that complaint/grievance.
If residents’ responses indicate problems in voicing grievances and getting grievances resolved, determine how the facility deals with and makes prompt efforts to resolve resident complaints and grievances.
• With permission, review resident council minutes.
• Interview staff about how grievances are handled.
• Interview staff about communication (to resident) of progress toward resolution of complaint/grievance.
If problems are identified, also investigate compliance with §483.10(b)(7)(iii).

§483.10(g) Examination of Survey Results

F167
A resident has the right to--

(1) 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 facility must make the results available for examination in a place readily accessible to residents and must post a notice of their availability; and
SEE GUIDANCE UNDER TAG 168
F168
A resident has the right to:

§483.10(g)(2) -- Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.

Interpretive Guidelines §483.10(g)(1)-(2)

“Results of the most recent survey” means the Statement of Deficiencies (Form CMS-2567) and the Statement of Isolated Deficiencies generated by the most recent standard survey and any subsequent extended surveys, and any deficiencies resulting from any subsequent complaint investigation(s).

“Made available for examination” means that survey results and approved plan of correction, if applicable, are available in a readable form, such as a binder, large print, or are provided with a magnifying glass, have not been altered by the facility unless authorized by the State agency, and are available to residents without having to ask a staff person.

“Place readily accessible to residents” is a place (such as a lobby or other area frequented by most residents) where individuals wishing to examine survey results do not have to ask to see them.

F169

§483.10(h) Work
The resident has the right to--

(1) Refuse to perform services for the facility;

(2) Perform services for the facility, if he or she chooses, when--

(i) The facility has documented the need or desire for work in the plan of care;

(ii) The plan specifies the nature of the services performed and whether the services are voluntary or paid;

(iii) Compensation for paid services is at or above prevailing rates; and

(iv) The resident agrees to the work arrangement described in the plan of care

Interpretive Guidelines §483.10(h)(1)-(2)

“Prevailing rate” is the wage paid to workers in the community surrounding the facility for essentially the same type, quality, and quantity of work requiring comparable skills.
All resident work, whether of a voluntary or paid nature, must be part of the plan of care. A resident’s desire for work is subject to discussion of medical appropriateness. As part of the plan of care, a therapeutic work assignment must be agreed to by the resident. The resident also has the right to refuse such treatment at any time that he or she wishes. At the time of development or review of the plan, voluntary or paid work can be negotiated.

Procedures §483.10(h)(1)-(2)
Are residents engaged in what may be paid or volunteer work (e.g., doing housekeeping, doing laundry, preparing meals)? Pay special attention to the possible work activities of residents with mental retardation or mental illness. If you observe such a situation, determine if the resident is in fact performing work and, if so, is this work, whether voluntary or paid, described in the plan of care?

§483.10(i) Mail
The resident has the right to privacy in written communications, including the right to--

$F_{170}$

§483.10(i)(1) Send and promptly receive mail that is unopened; and
 SEE GUIDANCE UNDER TAG 171

$F_{171}$

§483.10(i)(2) Have access to stationery, postage, and writing implements at the resident’s own expense.

Interpretive Guidelines §483.10(i)(1)-(2)
“Promptly” means delivery of mail or other materials to the resident within 24 hours of delivery by the postal service (including a post office box) and delivery of outgoing mail to the postal service within 24 hours, except when there is no regularly scheduled postal delivery and pick-up service.

$F_{172}$
(Rev. 48; Issued: 06-12-09; Effective/Implementation Date: 06-12-09)

§483.10(j) - Access and Visitation Rights

§483.10(j)(1) - The resident has the right and the facility must provide immediate access to any resident by the following:

(i) Any representative of the Secretary;

(ii) Any representative of the State;
(iii) The resident’s individual physician;

(iv) The State long term care ombudsman (established under section 307 (a)(12) of the Older Americans Act of 1965);

(v) The agency responsible for the protection and advocacy system for developmentally disabled individuals (established under part C of the Developmental Disabilities Assistance and Bill of Rights Act);

(vi) The agency responsible for the protection and advocacy system for mentally ill individuals (established under the Protection and Advocacy for Mentally Ill Individuals Act);

(vii) Subject to the resident’s right to deny or withdraw consent at any time, immediate family or other relatives of the resident; and

(viii) Subject to reasonable restrictions and the resident’s right to deny or withdraw consent at any time, others who are visiting with the consent of the resident.

§483.10(j)(2) - The facility must provide reasonable access to any 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.

Interpretive Guidelines: §483.10(j)(1) and (2)

The facility must provide immediate access to any representative of the Secretary of the Department of Health and Human Services, the State, the resident’s individual physician, the State long term care ombudsman, or the agencies responsible for the protection and advocacy of individuals with developmental disabilities or mental illness. The facility cannot refuse to permit residents to talk with surveyors. Representatives of the Department of Health and Human Services, the State, the State long term care ombudsman system, and protection and advocacy agencies for individuals with developmental disabilities or mental illness are not subject to visiting hour limitations.

Immediate family or other relatives are not subject to visiting hour limitations or other restrictions not imposed by the resident. Likewise, facilities must provide 24-hour access to other non-relative visitors who are visiting with the consent of the resident. These other visitors are subject to “reasonable restrictions” according to the regulatory language. “Reasonable restrictions” are those imposed by the facility that protect the security of all the facility’s residents, such as keeping the facility locked at night; denying access or providing limited and supervised access to a visitor if that individual has been found to be abusing, exploiting, or coercing a resident; denying access to a visitor who has been found to have been committing criminal acts such as theft; or denying access to visitors who are inebriated and disruptive. The facility may change the location of visits to assist care giving or protect the privacy of other residents, if these visitation rights infringe upon the rights of other residents in the facility. For
example, a resident’s family visits in the late evening, which prevents the resident’s roommate from sleeping.

An individual or representative of an agency that provides health, social, legal, or other services to the resident has the right of “reasonable access” to the resident, which means that the facility may establish guidelines regarding the circumstances of the visit, such as location. If there are problems with the facility’s provision of reasonable privacy for resident to meet with these representatives, refer to §483.10(e), Privacy and Confidentiality, Tag F164.

**Procedures: §483.10(j)(1) and (2)**

Do residents and family members know that they are able to visit 24-hours a day? Do non-relative visitors know they are also able to visit 24-hours a day, but subject to reasonable restrictions as defined above? If you identify problems during resident, family, or group interviews, determine how the facility ensures 24-hour access to:

• Representatives of the State;

• Representatives of the U.S. Department of Health and Human Services;

• The resident’s individual physician;

• Representatives of the State long-term care ombudsman;

• Representatives of agencies responsible for protecting and advocating rights of persons with mental illness or developmental disabilities;

• Immediate family or other relatives; and

• Other visitors, subject to reasonable restrictions as defined above.

____________________________________________________________________

F173

§483.10(j)(3) — The facility must allow representatives of the State Ombudsman, described in paragraph (j)(1)(iv) of this section, to examine a resident’s clinical records with the permission of the resident or the resident’s legal representative, and consistent with State law.

**Procedures §483.10(j)(3)**

Ask the ombudsman if the facility allows him/her to examine residents’ clinical records with the permission of the resident, and to the extent allowed by State law.
§483.10(k) Telephone
The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard.

Interpretive Guidelines §483.10(k)

Telephones in staff offices or at nurses’ stations do not meet the provisions of this requirement. Examples of facility accommodations to provide reasonable access to the use of a telephone without being overheard include providing cordless telephones or having telephone jacks in residents’ rooms.

“Reasonable access” includes placing telephones at a height accessible to residents who use wheelchairs and adapting telephones for use by the residents with impaired hearing.

§483.10(l) Personal Property
The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

Intent §483.10(l)
The intent of this regulation is to encourage residents to bring personal possessions into the facility, as space, safety considerations and fire code permits.

Interpretive Guidelines §483.10(l)
All residents’ possessions, regardless of their apparent value to others, must be treated with respect, for what they are and for what they may represent to the resident. The right to retain and use personal possessions assures that the residents’ environment be as homelike as possible and that residents retain as much control over their lives as possible. The facility has the right to limit the resident’s exercise of this right on grounds of space and health or safety.

Procedures §483.10(l)
If residents’ rooms have few personal possessions, ask residents, families and the local ombudsman if:

• Residents are encouraged to have and to use them;

• The facility informs residents not to bring in certain items and for what reason; and

• Personal property is safe in the facility.

Ask staff if the facility sets limits on the value of the property that residents may have in their possession or requires that residents put personal property in the facility’s safe.
§483.10(m) - Married Couples
The resident has the 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.

Interpretive Guidelines: §483.10(m)

The right of residents who are married to each other to share a room does not give a resident the right, or the facility the responsibility, to compel another resident to relocate to accommodate a spouse. The requirement means that when a room is available for a married couple to share, the facility must permit them to share it if they choose. If a married resident’s spouse is admitted to the facility later and the couple want to share a room, the facility must provide a shared room as quickly as possible. However, a couple is not able to share a room if one of the spouses has a different payment source for which the facility is not certified (if the room is in a distinct part, unless one of the spouses elects to pay for his or her care). This regulation does not prohibit the facility from accommodating residents who wish to room with another nursing home resident of their choice. For issues of residents being prohibited from rooming with persons of their choice, use §483.15(b)(3), Self-determination and Participation, Tag F242: “The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident.”

§483.10(n) Self-Administration of Drugs
An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.

Interpretive Guidelines §483.10(n)
If a resident requests to self-administer drugs, it is the responsibility of the interdisciplinary team to determine that it is safe for the resident to self-administer drugs before the resident may exercise that right. The interdisciplinary team must also determine who will be responsible (the resident or the nursing staff) for storage and documentation of the administration of drugs, as well as the location of the drug administration (e.g., resident’s room, nurses’ station, or activities room). Appropriate notation of these determinations should be placed in the resident’s care plan. The decision that a resident has the ability to self-administer medication(s) is subject to periodic re-evaluation based on change in the resident’s status. The facility may require that drugs be administered by the nurse or medication aide, if allowed by State law, until the care planning team has the opportunity to obtain information necessary to make an assessment of the resident’s ability to safely self-administer medications. If the resident chooses to self-administer drugs, this decision should be made at least by the time the care plan is completed within seven days after completion of the comprehensive assessment.
Medication errors occurring with residents who self-administer drugs should not be counted in the facility’s medication error rate (see Guidelines for §483.25(m)), but should call into question the judgment made by the facility in allowing self-administration for those residents.

Probes: §483.10(n)
For residents selected for a comprehensive review or a focused review, as appropriate:

- Does resident self-administer drugs? Which ones? How much? How often?
- Does the care plan reflect self-administration?

§483.10(o) Refusal of Certain Transfers

(1) An individual has the right to refuse a transfer to another room within the institution, if the purpose of the transfer is to relocate--

(i) A resident of a SNF, from the distinct part of the institution that is a SNF to a part of the institution that is not a SNF, or

(ii) A resident of a NF, from the distinct part of the institution that is a NF to a distinct part of the institution that is a SNF.

(2) A resident’s exercise of the right to refuse transfer under paragraph (o)(1) of this section does not affect the individual’s eligibility or entitlement to Medicare or Medicaid benefits.

Interpretive Guidelines §483.10(o)
This requirement applies to transfer within a physical plant.
These provisions allow a resident to refuse transfer from a room in one distinct part of an institution to a room in another distinct part of the institution for purposes of obtaining Medicare or Medicaid eligibility. If a resident refuses to transfer from a portion of the institution that is not Medicare certified, the resident forgoes the possibility of Medicare coverage for the care received there. If that portion of the institution is Medicaid certified and the resident is Medicaid-eligible, then Medicaid covered services would be paid by Medicaid. If the resident is Medicaid-eligible, but that portion of the institution is not Medicaid certified, then the resident would assume responsibility for payment for the services. If the resident is unable to pay for those services, then the facility may, after giving the resident a 30-day notice, transfer the resident under the provisions of §483.12(a).

When a resident occupies a bed in a distinct part NF that participates in Medicaid and not in Medicare, he or she may not be moved involuntarily to another part of the institution by the facility (or required to be moved by the State) solely for the purpose of assuring Medicare eligibility for payment. Such moves are only appropriate when they occur at the request of a
resident (for example, when a privately paying Medicare beneficiary believes that admission to a bed in a Medicare-participating distinct part of the institution may result in Medicare payment). See Guidelines, §483.12 for further discussion regarding transfers.

For transfers of residents between Medicare or Medicaid approved distinct parts:

- Is there a documented medical reason for the transfer?
- Was the resident transferred because of a change in payment source?
- If a Medicare or Medicaid resident is notified that he/she is no longer eligible, does the facility transfer the resident? Did the facility give the resident the opportunity to refuse the transfer? How? What happened?

Ask the local ombudsman about facility compliance with transfer requirements. See also §483.12, Criteria for Transfer.