

Nursing Home Toolkit

Program Integrity and Quality of Care—An Overview for Nursing Home Providers





Content Summary

This booklet is written for nursing home providers that participate in the Medicaid program. It contains information on the definitions for fraud, waste, and abuse, and common types of fraud in the nursing home environment. This booklet also discusses improper payments and government anti-fraud efforts.

After addressing common program integrity issues, the booklet covers quality of care in the nursing home, such as quality of life, resident rights, and resident freedom from fraud and abuse. The booklet concludes with information on how to report concerns and problems in the nursing home.

As a nursing home provider, you can improve the quality of life for the people you serve. By providing a caring environment, you can help residents feel safe and secure, which may offer their family members peace of mind.

Nursing homes are a necessary service for many Americans. However, since 1996 the U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG) has identified a number of problems with billing by nursing facilities that participate in the Medicare and Medicaid programs, including the submission of inaccurate, medically unnecessary, and fraudulent claims.[1, 2, 3] Many nursing facilities receive payment from both Medicare and Medicaid for services provided to their residents. Therefore, Centers for Medicare & Medicaid Services (CMS) guidance for nursing facilities may address concerns in both the Medicare and Medicaid programs.[4] These concerns include quality of care, submission of accurate claims, the Federal Anti-Kickback Statute, and other areas of risk. Understanding fraud, waste, and abuse can help providers avoid errors that could cause problems for themselves or the facilities in which they work.

As with the Medicare program, Medicaid fraud, waste, and abuse, as well as the quality of the care provided, are major concerns. This booklet provides an overview of Medicaid provider program integrity rules and discusses nursing home quality of care services.

Definitions of Fraud, Waste, and Abuse

- **Waste**

Waste is not defined in Medicaid program integrity rules but is “generally understood to encompass the over-utilization or inappropriate utilization of services and misuse of resources, and typically is not a criminal or intentional act.”[5] Examples of waste might include a health care prescriber ordering more medical supplies than the beneficiary needs or ordering excessive laboratory tests.

- **Abuse**

“Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.”[6]

Abuse can include charging excessively for services or supplies, or billing for services that are not medically necessary.[7]

- **Fraud**

Fraud is “an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.”[8]

Neither waste nor abuse requires provider intent to illegally profit from the Medicaid program, but penalties may still apply. On the other hand, fraud involves intent and is a crime. Waste and abuse may not be done intentionally, but such conduct harms everyone involved by increasing the cost of health care and raising red flags about program integrity or fraudulent behavior. Providers found to have defrauded the Medicaid program may be subject to civil[9] and/or criminal[10] liability, Civil Monetary Penalties,[11] and exclusion[12] from participation in public health care programs like Medicaid or Medicare. Penalties and fines are reported on the Nursing Home Compare report.[13]

Types of Fraud, Waste, and Abuse

- **Billing for Unnecessary Services or Items**

To be covered by Medicare or Medicaid, services must be medically necessary. For Medicaid, each State defines medical necessity. Under 42 C.F.R. § 440.230(d), States may “place appropriate limits on a service based on such criteria as medical necessity” Physicians are responsible for ensuring that authorized services meet the definition of medical necessity in the States in which they practice. When a physician signs billing documents, he or she certifies the truth, accuracy, and completeness of the claims.[14] A provider who knowingly bills Medicaid for unnecessary services or items may be found to have committed fraud. In 2011, a former nursing home administrator pled guilty to charges she defrauded the Medicaid program out of \$2.2 million. She allegedly exaggerated residents’ diagnoses, conditions, and required services. She also allegedly reported providing treatments for the exaggerated diagnoses, including suction and oxygen treatments, and treatment for cancer and infections that were not required. She was ordered to repay Medicaid, and is excluded from participating in federally funded health care programs.[15]

- **Billing for Services Not Rendered**

To be covered by Medicaid, the billed service or supply must in fact be provided. Providers should only bill for the services or items authorized by their State’s Medicaid program and for services actually furnished to beneficiaries. Some fraudulent providers bill Medicaid for a covered service or item that was never provided. These providers may create false records in an attempt to justify the bills. For example, a former nursing home administrator was convicted of defrauding the Georgia Medicaid and Medicare programs by billing them for \$32.9 million in worthless services. Between 2004 and 2007, the defendant billed Medicaid and Medicare for food, medical care, and other services for nursing home residents. Evidence presented at the trial showed conditions at the nursing homes were very poor, including, no nursing or housekeeping supplies, food shortages, poor sanitary conditions, hazardous physical environment, and inadequate staffing. The former nursing home administrator was sentenced to 20 years in prison, followed by 3 years of supervised release. In addition, he was ordered to pay more than \$6.7 million in restitution to Medicaid and Medicare.[16]

- **Upcoding**

Upcoding is a term that is not defined in the regulations but is generally understood as billing for services at a level of complexity that is higher than the service actually provided or documented in the file.[17] For example, it was alleged that a clinical social worker billed Medicaid for 45 to 50 minutes of individual therapy when in fact he provided less than 30 minutes of counseling services. It was also alleged that the clinical social worker billed Medicaid for individual psychotherapy services for separate family members when he actually provided one group therapy session to the family members at the same time. The clinical social worker entered into a civil settlement with Federal and State governments in which he will pay \$210,000 and will be excluded from Medicare, Medicaid, and all other Federal health care programs for 5 years.[18]

- **Unbundling**

According to the National Correct Coding Initiative Manual for Medicaid, “Unbundling occurs when multiple procedure codes are billed for a group of procedures that are covered by a single comprehensive code.[19] For example, a laboratory might receive an order for a panel of tests on a patient. Instead of appropriately bundling the tests and billing for them together, the laboratory might attempt to increase its income by billing for each test separately.

- **Kickbacks**

The Anti-Kickback Statute prohibits the knowing, soliciting, receiving, offering, or paying of remuneration (in kind or in cash) to induce or in return for the referral of individuals for any item or service for which payment may be made under Federal health care programs.[20, 21] For example, Omnicare, a corporation that specializes in providing pharmacy services to long-term care facilities, and IVAX Pharmaceuticals (IVAX), a corporation that manufactures generic drugs, allegedly engaged in unlawful kickback schemes. It was alleged that Omnicare solicited and received \$8 million from IVAX in exchange for Omnicare’s purchasing of \$50 million in generic drugs from IVAX and for pushing nursing home residents to use those drugs. It was also alleged that Omnicare paid \$50 million to nursing homes in exchange for long-term contracts to refer residents to Omnicare for their drug purchases. Omnicare and IVAX entered into settlements to return \$112 million to State and Federal governments for Medicaid and Medicare programs. They also entered into Corporate Integrity Agreements with the HHS-OIG that will monitor future practices.[22]

- **Medical Identity Theft**

Medical identity theft is “the appropriation or misuse of a patient’s or [provider’s] unique medical identifying information to obtain or bill public or private payers for fraudulent medical goods or services.”[23]

Protecting the medical and personal identity of health care professionals and residents is the responsibility of the nursing home.

Visit the website of HHS-OIG at <https://oig.hhs.gov/fraud/enforcement/criminal/> to learn about more provider fraud prosecutions and settlements.

Anti-Fraud Efforts

“CMS is committed to combating Medicaid provider fraud, waste, and abuse which diverts dollars that could otherwise be spent to safeguard the health and welfare of Medicaid recipients.”[24] CMS combats Medicaid provider fraud, waste, and abuse by hiring “contractors to review Medicaid provider activities, audit claims, identify overpayments, and educate providers and others on Medicaid program integrity issues” and by providing “effective support and assistance to States . . .”[25] Through these efforts, investigations leading to criminal fraud charges can occur.

Investigations that lead to criminal fraud charges often start with identification of improper payments. Improper payments are those that should not have been made or that were made in an incorrect amount (overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. Such payments “include those made for treatments or services that were not covered by program rules, that were not medically necessary, or that were billed for but never provided.”[26] Thus, improper payments may be a result of fraud, waste, and abuse.[27] Medicaid utilizes the following audits to identify improper payments:

- CMS Payment Error Rate Measurement program, which measures and reports improper payments in Medicaid and identifies common errors;[28]
- Audit Medicaid Integrity Contractors, which contract with CMS to perform audits and identify Medicaid overpayments;[29] and
- Medicaid Recovery Audit Contractors, which contract with States to audit providers and identify overpayments.[30]



Quality of Care

As a nursing home provider, not only are you responsible for maintaining program integrity by submitting accurate documented billing, but you are also responsible for providing quality care for all residents that creates and sustains “an environment that humanizes and individualizes each resident.”[31]

The Social Security Act requires each nursing home to protect and promote the rights of its residents, including the right to free choice, the right to be free from restraints, and the right to ensure dignity, privacy, confidentiality, and respect.[32] All nursing homes “... must provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial needs of each resident”[33] Thus, a resident’s health and quality of life should not decline due to his or her stay in a nursing home without a medical reason.

Some examples of inadequate quality care may include malnutrition, pressure ulcers, uncontrolled pain, and the use of hypnotic and antipsychotic medications when there is no clinical indication documented.[34]

“It is often asserted that the quality of care in nursing homes is impaired because staffing is inadequate, staff is insufficiently trained, and turnover is high, especially for certified nurse assistants Inadequate staffing is one of the most common complaints about nursing home care.”[35]

The Social Security Act requires certain staffing levels for registered nurses and licensed practical nurses. Specifically, Medicare- and Medicaid-certified nursing homes are required to have a registered nurse as the director of nursing; a registered nurse on duty at least 8 hours a day, 7 days a week; and a licensed nurse (registered nurse or licensed practical nurse) on duty the rest of the time.[36]

Quality care means the care provided to the member should be necessary and correct; meet acceptable standards of practice; meet the individualized preferences and needs of the resident; and be given with respect.[37]

Residents' Rights

Nursing home residents with Medicaid coverage have rights and protections under the law. These include, but are not limited to, the right to:

- Be treated with dignity and respect;
- Manage his or her own money or choose someone else to manage it, including the nursing home;
- Use his or her own personal belongings as long as it does not affect others, and as space and safety permit;
- Be given privacy and confidentiality;
- Be informed about services, patient condition, and medications;
- Refuse medications and treatments and participate in decisions and care planning;[38]
- Participate in making choices in care; and
- Make independent choices, including choosing a physician.[39]

Abuse and Neglect of Residents in a Nursing Home

Not only do nursing home residents deserve quality care, but more importantly, they deserve to live free from fear of abuse and neglect. In most cases, nursing home staff members provide care and services that are helpful and appropriate to the residents. However, there may be times when this is not the case and appropriate care is not being provided. It is important to understand the difference between abuse and neglect, to recognize the signs, and to know how to report it if there is a concern.

Neglect is the “failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.”[40] On the other hand, “abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.”[41] Residents have the “right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.”[42]



Many nursing home residents keep money in an account at the nursing home called a Resident Trust Account. The nursing home is responsible for managing this account appropriately. One form of abuse is misappropriation or misuse of property or funds that belong to the nursing home resident. This involves nursing home staff misplacing or misusing the resident's money or personal property without consent.[43]

Some possible signs of physical or emotional abuse and neglect may include:

- Weight loss;
- Lack of bathing;
- Too much or not enough medication;
- Unnecessary restraints (physical or medicinal);
- Lack of fall and injury precautions;
- Fear, anxiety, or depression;
- Bruises, wounds, or broken bones;
- Sores due to lack of position changes;
- Soiled undergarments or bedding;
- Verbal mistreatment; and
- Missing personal property

Report Suspect Acts

If you have concerns about the treatment of a nursing home resident, you can contact your local ombudsman. To find one in your area visit http://theconsumervoice.org/get_help on the National Consumer Voice for Quality Long-Term Care website.[44]

Report any acts of physical abuse of a nursing home resident to your State's Medicaid Fraud Control Unit (MFCU). Contact information for MFCUs is available at <https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/files/contact-directors.pdf> on the HHS-OIG website. It is the agency's job to investigate allegations of patient abuse in nursing homes.

Office of Inspector General
U.S. Department of Health and Human Services
ATTN: Hotline
P.O. Box 23489
Washington, D.C. 20026
Phone: 1-800-HHS-TIPS (1-800-447-8477)
TTY: 1-800-377-4950
Fax: 1-800-223-8164
Email: HHSTips@oig.hhs.gov
Website: <https://forms.oig.hhs.gov/hotlineoperations/>



Conclusion

Nursing homes are a needed resource. Fraud takes valuable resources from needed services. Nursing home providers can assist in stopping fraud, waste, and abuse by understanding the common types of fraud.

Each nursing home resident has the right to quality care, which includes specific rights and freedom from abuse and neglect. If you have concerns or suspect problems in the nursing home, report them.

References

- 1 U.S. Department of Health and Human Services. Office of Inspector General. (1996, May). Fraud and Abuse in the Provision of Services in Nursing Facilities (p.1). Retrieved June 9, 2014, from <https://oig.hhs.gov/fraud/docs/alertsandbulletins/SFANursingFacilities.pdf>
- 2 U.S. Department of Health and Human Services. Office of Inspector General. (2008, September 30). OIG Supplemental Compliance Program Guidance for Nursing Facilities. 73 Fed. Reg. 56832. Retrieved June 9, 2014, from http://oig.hhs.gov/compliance/compliance-guidance/docs/complianceguidance/nhg_fr.pdf
- 3 U.S. Department of Health and Human Services. Office of Inspector General. 2014 Work Plan. Retrieved June 9, 2014, from <http://oig.hhs.gov/reports-and-publications/archives/workplan/2014/Work-Plan-2014.pdf>
- 4 U.S. Department of Health and Human Services. Office of Inspector General. (2008, September 30). OIG Supplemental Compliance Program Guidance for Nursing Facilities. 73 Fed. Reg. 56832. Retrieved June 9, 2014, from http://oig.hhs.gov/compliance/compliance-guidance/docs/complianceguidance/nhg_fr.pdf
- 5 National Association of Medicaid Directors. (2012, March). Rethinking Medicaid Program Integrity: Eliminating Duplication and Investing in Effective, High-Value Tools (p. 4). Retrieved June 11, 2014, from http://medicaidirectors.org/sites/medicaidirectors.org/files/public/namd_medicaid_pi_position_paper_final_120319.pdf
- 6 Definitions, 42 C.F.R. § 455.2. Retrieved June 11, 2014, from <http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=fc26d3ad7c6b1cf5fce11e4865f89c37&ty=HTML&h=L&n=42y4.0.1.1.13&r=PART#42:4.0.1.1.13.0.130.2>
- 7 Centers for Medicare & Medicaid Services. (2012, November). Medicare Fraud & Abuse: Prevention, Detection, and Reporting (p. 2). Retrieved June 11, 2014, from http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Fraud_and_Abuse.pdf
- 8 Definitions, 42 C.F.R. § 455.2. Retrieved June 11, 2014, from <http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=fc26d3ad7c6b1cf5fce11e4865f89c37&ty=HTML&h=L&n=42y4.0.1.1.13&r=PART#42:4.0.1.1.13.0.130.2>
- 9 False Claims Act, 31 U.S.C. § 3729 (2009). Retrieved June 11, 2014, from [http://uscode.house.gov/view.xhtml?req=\(title:31%20section:3729%20edition:prelim\)%20OR%20\(granuleid:USC-prelim-title31-section3729\)&f=treesort&edition=prelim&num=0&jumpTo=true](http://uscode.house.gov/view.xhtml?req=(title:31%20section:3729%20edition:prelim)%20OR%20(granuleid:USC-prelim-title31-section3729)&f=treesort&edition=prelim&num=0&jumpTo=true)
- 10 False, Fictitious or Fraudulent Claims. 18 U.S.C. § 287 (1986). Retrieved June 11, 2014, from [http://uscode.house.gov/view.xhtml?req=\(title:18%20section:287%20edition:prelim\)%20OR%20\(granuleid:USC-prelim-title18-section287\)&f=treesort&edition=prelim&num=0&jumpTo=true](http://uscode.house.gov/view.xhtml?req=(title:18%20section:287%20edition:prelim)%20OR%20(granuleid:USC-prelim-title18-section287)&f=treesort&edition=prelim&num=0&jumpTo=true)
- 11 Social Security Act § 1128A, 42 U.S.C. § 1320a-7a (2011). Retrieved June 11, 2014, from http://www.ssa.gov/OP_Home/ssact/title11/1128A.htm
- 12 Social Security Act § 1128(b)(6)(B), 42 U.S.C. § 1320a-7 (2011). Retrieved June 11, 2014, from http://www.socialsecurity.gov/OP_Home/ssact/title11/1128.htm
- 13 The Official U.S. Government Site for Medicare. Nursing Home Compare. Retrieved June 11, 2014, from <http://www.medicare.gov/nursinghomecompare/search.html?AspxAutoDetectCookieSupport=1>
- 14 Provider's Statements on Claims Forms, 42 C.F.R. § 455.18. Retrieved June 11, 2014, from <http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=41c746bbf99a30178ede53d1c13b33a7&ty=HTML&h=L&r=SECTION&n=42y4.0.1.1.13.1.130.7>

- 15 New York State Office of the Attorney General. (2011, September 8). A.G. Schneiderman Secures Prison Time for Nursing Home Employee Who Committed \$2.2 Million Medicaid Fraud. Retrieved June 9, 2014, from <http://www.ag.ny.gov/press-release/ag-schneiderman-secures-prison-time-nursing-home-employee-who-committed-22-million>
- 16 United States Attorney's Office. Northern District of Georgia. (2012, August 13). Former Nursing Home Operator Sentenced to Prison for 20 Years for Health Care Fraud and Tax Fraud. Retrieved June 10, 2014, from <http://www.fbi.gov/atlanta/press-releases/2012/former-nursing-home-operator-sentenced-to-prison-for-20-years-for-health-care-fraud-and-tax-fraud>
- 17 U.S. Department of Health and Human Services. Office of Inspector General. (2010, March 4). Testimony of Inspector General Daniel R. Levinson Before the House Appropriations Committee. Subcommittee on Labor, Health and Human Services, Education, and Related Agencies (p. 2). Retrieved March 25, 2014, from <https://oig.hhs.gov/testimony/docs/2010/3-4-10LevinsonHAppropsSub.pdf>
- 18 U.S. Attorney's Office. District of Connecticut. (2011, July 8). New Milford Clinical Social Worker Pays \$210,000 to Settle Allegations Under the False Claims Act. Retrieved June 9, 2014, from <http://www.justice.gov/usao/ct/Press2011/20110708.html>
- 19 Provistas, Incorporated. (2010). Correct Coding Initiative Data–2010. Version 16.1. April 1–June 30 (p. 3) Retrieved June 13, 2014, from http://www.medical-coding.net/media/samplepages/CCI-EB16.1_CCI_2010%20eb%20sample.pdf
- 20 Social Security Act § 1128B(b), 42 U.S.C. 1320a-7b(b) (2011). Retrieved March 25, 2014, from http://www.ssa.gov/OP_Home/ssact/title11/1128B.htm
- 21 U.S. Department of Health and Human Services. Office of Inspector General. A Roadmap for New Physicians: Avoiding Medicare and Medicaid Fraud and Abuse (p. 4). Retrieved March 25, 2014, from https://oig.hhs.gov/compliance/physician-education/roadmap_web_version.pdf
- 22 North Carolina Department of Justice. (2010, April 28). AG's Medicaid Fraud Investigators Recover \$3.4 Million for NC. Retrieved June 10, 2014, from [http://www.ncdoj.gov/News-and-Alerts/News-Releases-and-Advisories/Press-Releases/AG's-Medicaid-fraud-investigators-recover-\\$3-4-mil.aspx](http://www.ncdoj.gov/News-and-Alerts/News-Releases-and-Advisories/Press-Releases/AG's-Medicaid-fraud-investigators-recover-$3-4-mil.aspx)
- 23 Department of Health and Human Services. Centers for Medicare & Medicaid Services. (2012, April). Medicaid Program Integrity: Understanding Provider Medical Identity Theft (p. 2). Retrieved June 13, 2014, from <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Med-ID-Theft-Booklet-ICN908264.pdf>
- 24 Centers for Medicare & Medicaid Services. Medicaid Integrity Program–General Information. Retrieved June 13, 2014, from <http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/MedicaidIntegrityProgram/index.html?redirect=/medicaidintegrityprogram>
- 25 Centers for Medicare & Medicaid Services. Medicaid Integrity Program–General Information. Retrieved June 13, 2014, from <http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/MedicaidIntegrityProgram/index.html?redirect=/medicaidintegrityprogram>
- 26 U.S. Government Accountability Office. (2012, June). Testimony. National Medicaid Audit Program. CMS Should Improve Reporting and Focus on Audit Collaboration With States (p. 1 and note 2). Retrieved June 13, 2014, from <http://www.gao.gov/assets/600/591601.pdf>
- 27 U.S. Government Accountability Office. (2012, June 7). Program Integrity. Further Action Needed to Address Vulnerabilities in Medicaid and Medicare Programs (p. 1, note 2). Retrieved June 13, 2014, from <http://www.gao.gov/assets/600/591425.pdf>
- 28 Centers for Medicare & Medicaid Services. Payment Error Rate Measurement (PERM). Retrieved June 13, 2014, from <https://www.cms.gov/perm/>
- 29 Centers for Medicare & Medicaid Services. (2009, July 15). Special Open Door Forum: Medicaid Integrity Provider Audit Program (p. 1). Retrieved June 13, 2014, from <http://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/downloads/MIPProviderAudits071509.pdf>
- 30 Centers for Medicare & Medicaid Services. (2011, December). Frequently Asked Questions, Section 6411(a) of the Affordable Care Act. Retrieved June 13, 2014, from https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/MedicaidIntegrityProgram/Downloads/scanned_document_29-12-2011.pdf
- 31 Medicaid State Operations Manual. Appendix PP–Guidance to Surveyors for Long Term Care Facilities. F240. Quality of Life. 42 C.F.R. § 483.15. Retrieved June 13, 2014, from http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf
- 32 Social Security Act §1919(c)(1). Quality of Life. Retrieved June 13, 2014, from http://www.socialsecurity.gov/OP_Home/ssact/title19/1919.htm

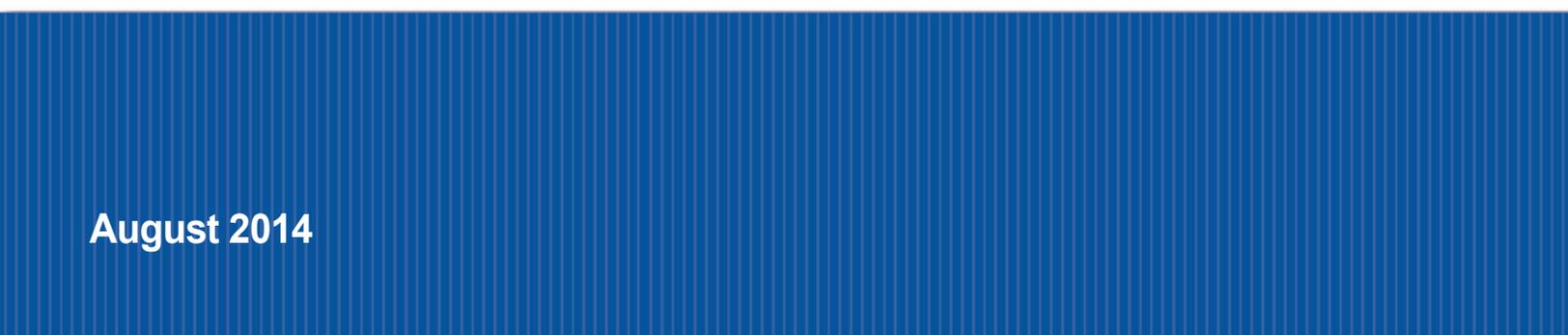
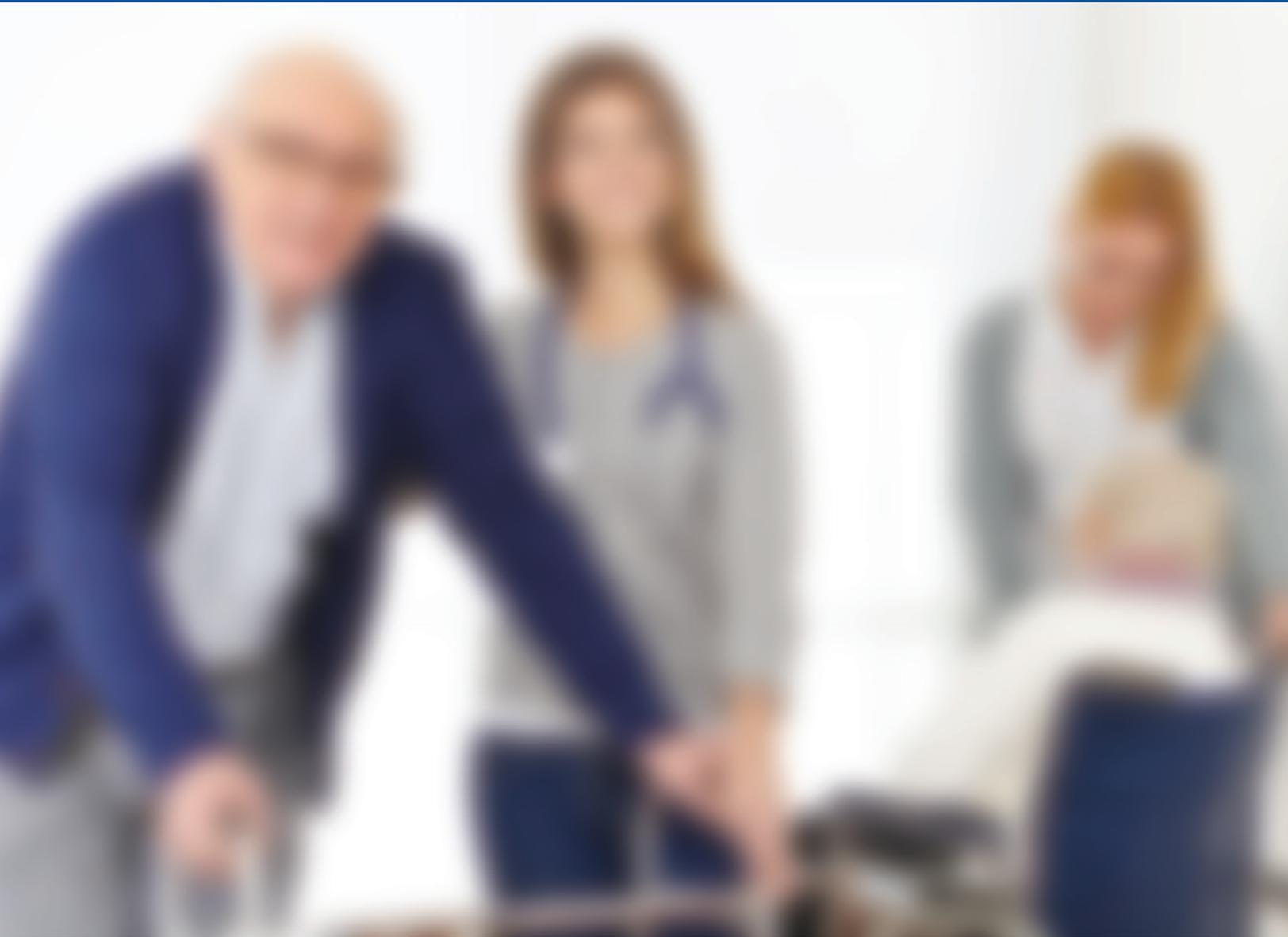
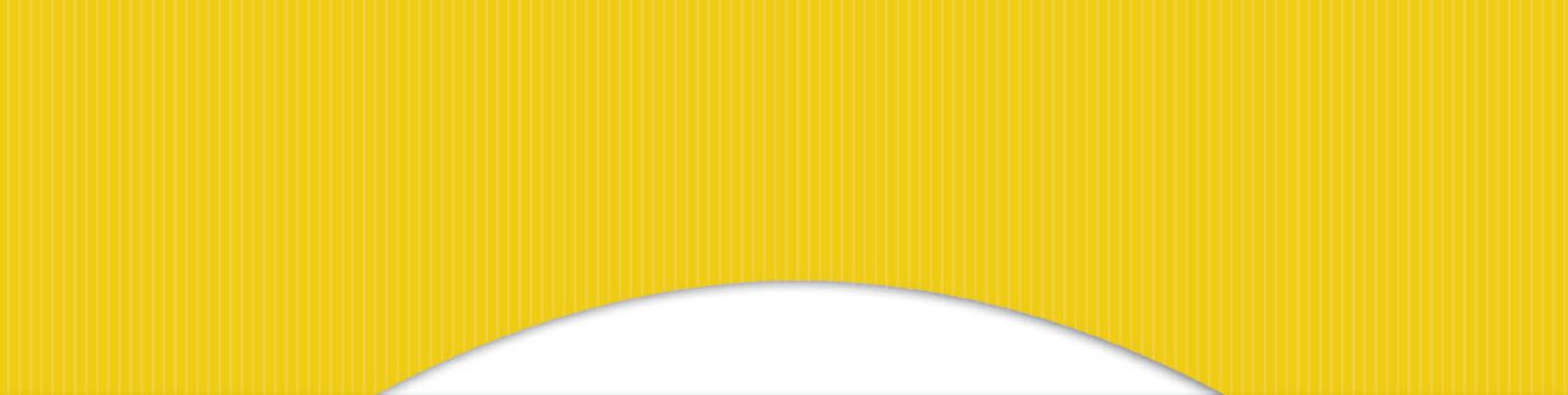
- 33 Social Security Act §1919(b)(2). Scope of Services and Activities Under Plan of Care. Retrieved June 13, 2014, from http://www.socialsecurity.gov/OP_Home/ssact/title19/1919.htm
- 34 Social Security Act §1919(b)(4). Provision of Services and Activities. Retrieved June 13, 2014, from http://www.socialsecurity.gov/OP_Home/ssact/title19/1919.htm
- 35 Weiner, J., Freiman, M., & Brown, D. (2007, December). Nursing Home Care Quality. Twenty Years After the Omnibus Budget Reconciliation Act of 1987 (p. 16). The Henry J. Kaiser Family Foundation. Retrieved June 13, 2014, from <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7717.pdf>
- 36 Required Nursing Care; Facility Waivers, 42 U.S.C. § 139. Retrieved June 13, 2014, from <http://www.law.cornell.edu/uscode/text/42/1396r>
- 37 Social Security Act §1919(b). Quality of Life. Retrieved June 13, 2014, from http://www.socialsecurity.gov/OP_Home/ssact/title19/1919.htm
- 38 Social Security Act §1919(c)(1). Quality of Life. Retrieved June 13, 2014, from http://www.socialsecurity.gov/OP_Home/ssact/title19/1919.htm
- 39 Social Security Act §1919(c). Requirements Relating to Residents' Rights. Retrieved June 13, 2014, from http://www.socialsecurity.gov/OP_Home/ssact/title19/1919.htm
- 40 Definitions, 42 C.F.R. § 488.301. Retrieved June 13, 2014, from <http://www.ecfr.gov/cgi-bin/text-idx?SID=cc7f5394b6bf1b100a769ed57badc7ce&node=42:5.0.1.1.6.5.14.2&rgn=div8>
- 41 Definitions, 42 C.F.R. § 488.301. Retrieved June 13, 2014, from <http://www.ecfr.gov/cgi-bin/text-idx?SID=cc7f5394b6bf1b100a769ed57badc7ce&node=42:5.0.1.1.6.5.14.2&rgn=div8>
- 42 Resident Behavior and Facility Practices, 42 C.F.R. § 483.13. Retrieved June 13, 2014, from <http://www.ecfr.gov/cgi-bin/text-idx?SID=97337d64ef0e3ed8cdf5be4ca3babe98&node=42:5.0.1.1.2.2.7.5&rgn=div8>
- 43 Social Security Act §1919(c)(6). Protection of Resident Funds. Retrieved June 13, 2014, from http://www.socialsecurity.gov/OP_Home/ssact/title19/1919.htm
- 44 The National Consumer Voice for Quality Long-Term Care. Locate an Ombudsman. Retrieved June 13, 2014, from http://theconsumervoice.org/get_help

Disclaimer

This booklet was current at the time it was published or uploaded onto the web. Medicaid and Medicare policies change frequently so links to the source documents have been provided within the document for your reference.

This booklet was prepared as a service to the public and is not intended to grant rights or impose obligations. This booklet may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. Use of this material is voluntary. Inclusion of a link does not constitute CMS endorsement of the material. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

August 2014



August 2014