Resident's Rights

November 14, 2011

By

Maureen Kroll, Esquire

Admission

A recommendation that an individual be admitted to a skilled nursing facility that participates in the Medicare program must be personally approved by a physician.[1] A resident or prospective resident of a skilled nursing facility which participates in the Medicare program cannot be required to waive any right to Medicare benefits, or to give oral or written assurance that the resident is not eligible for, or will not apply for, Medicare benefits.[2] Nor may a third party be required to guarantee payment to the facility as a condition of admission or expedited admission to, or continued stay in, the facility.[3] However, an individual who has legal access to a resident's income or resources available to pay for facility care may be required by the facility to sign a contract, without incurring personal financial liability, to pay for the care.[4] In addition, an organization or person unrelated to the resident or potential resident may be solicited for or give a charitable, religious, or philanthropic contribution, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility.[5]

ASSESSMENT

At the time each resident is admitted to a skilled nursing facility which participates in the Medicare program, the facility must have physician orders for the resident's immediate care.[1] Then, the resident's functional capacity must be determined in a comprehensive, accurate, standardized, reproducible assessment conducted by the facility.[2]

The assessment of a resident's functional capacity must describe the beneficiary's capability to perform daily life functions and significant impairments, must be based on uniform minimum data specified by the Secretary of Health and Human Services, and must use a state-specified instrument.[3] At a minimum, the assessment must include information regarding the resident's medically defined conditions and prior medical history; medical status measurement; functional status; sensory and physical impairments; nutritional status and requirements; special treatments or procedures; psychosocial status; discharge potential; dental condition; activities potential; rehabilitation potential; cognitive status; and drug therapy.[4]

ASSESSMENT - FREQUENCY

Initial and periodic assessments must be conducted for each resident in a skilled nursing facility which participates in Medicare.[1] The initial assessment must be conducted no later than 14 days after the date of admission.[2] Although the Social Security Act provides that the initial assessment must be conducted by January 1, 1991, for each resident of a facility on October 1, 1990,[3] the regulations provide that the assessment must be conducted no later than 14 days after the date of admission.[4] A comprehensive, periodic assessment must be made promptly when there is a significant change in a resident's physical or mental condition,[5] and must be conducted for each resident at least once every 12 months.[6] To assure the continuing accuracy of the assessment, each resident's assessment must be revised as appropriate on the basis of an examination of the resident which must be conducted by the facility no less frequently than once every three months.[7]

CARE PLANS

The results of a skilled nursing facility resident's assessments are used to develop, review, and revise a comprehensive care plan for the resident.[1] The initial care plan, prepared by an interdisciplinary team which includes the resident, the resident's family, or the resident's legal representative,[2] must be completed within seven days after completion of the resident's comprehensive assessment,[3] and must include measurable objectives and timetables to meet the medical, nursing, and psychosocial needs identified in the resident's comprehensive assessment.[4] The plan must be reviewed and revised by the team after each subsequent comprehensive assessment.[5]

Protection of Resident's Funds

Residents in skilled nursing facilities that participate in the Medicare program have the right to manage their own financial affairs,[1] and may not be required to deposit personal funds with the facility.[2] Furthermore, personal funds may not be imposed with a fee by the facility for any item or service for which payment is made under Medicare.[3]

A resident who gives the facility written authorization to hold, safeguard, manage, and account for personal funds which are deposited with the facility[4] is entitled to have personal funds in excess of $100 deposited in an interest bearing account that is separate from any of the facility's operating accounts and that credits all interest earned on the funds to the resident's account,[5] to have any other personal funds maintained in a noninterest bearing account or petty cash fund,[6] and to have the resident's financial record made available on request to the resident, or the resident's legal representative.[7] Each resident is entitled to a full and complete separate accounting of personal funds[8] pursuant to an accounting system which precludes any commingling of resident funds with facility funds or with the funds of any person other than another resident.[9] Upon the death of a resident who has a personal funds account with the facility, the facility must promptly convey the personal funds and a final accounting of the funds to the individual administering the resident's estate.[10]

Observation:

The facility is required to purchase a surety bond, or provide self-insurance to assure the security of all resident personal funds deposited with the facility.[11]

Record of Legal Representative or Interested Family Member

Each resident in a skilled nursing facility which participates in Medicare is entitled to have the facility record and periodically update the address and telephone number of the resident's legal representative or interested family member.[1]

Grievances

A resident in a skilled nursing facility which participates in the Medicare program has the right to voice grievances with respect to treatment and care, without discrimination or reprisal, and to receive prompt efforts by the facility to resolve grievances, including those with respect to the behavior of other residents.[1]

Freedom from Abuse and Restraints

A resident in a skilled nursing facility which participates in the Medicare program has the right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints which are imposed for purposes of discipline or convenience, not to treat the resident's medical symptoms.[1] Restraints may be imposed upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used, but only to insure the safety of the resident or other residents, provided that the Secretary of Health and Human Services may specify circumstances in which emergency use of restraints is permitted until an order can reasonably be obtained.[2]

Observation:

Each facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, or abuse of residents; must insure that all alleged violations are immediately reported to the facility administrator or other officials; must have evidence that all alleged violations are thoroughly investigated; must prevent further potential abuse while the investigation is in progress; must report the results of all investigations to the administrator or other officials within five working days of the incident being investigated; and, if the alleged violation is verified, must take appropriate corrective action.[3]

Formulation of Advanced Directive

A skilled nursing facility must maintain written policies and procedures regarding advance directives, including 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, to formulate an advance directive.[1]

Protection of Rights

Each resident in a skilled nursing facility who participates in the Medicare program is entitled to have the facility protect and promote the resident's rights.[1] In addition, the resident has the right to examine the results of the most recently conducted survey of the facility by federal or state surveyors, and any plan of correction in effect with respect to the facility.[2] The results must be posted by the facility in a place readily accessible to residents.[3]

Observation:

Each state that has signed an agreement with the Secretary of Health and Human Services[4] has an obligation to certify, based on a standard survey of each participating skilled nursing facility in the state, whether the facility is complying with requirements relating to resident rights, and to investigate allegations of resident neglect and abuse, and misappropriation of resident property;[5] based on findings by the state or the beneficiary's own findings, the Secretary of Health and Human Services is authorized to remedy a skilled nursing facility's noncompliance by denying Medicare payments to the facility, imposing civil penalties of up to $10,000 for each day of noncompliance, appointing temporary management to oversee the operation of the facility, and terminating the facility's participation in Medicare.[6]

Notice of Rights and Services

A resident in a skilled nursing facility which participates in the Medicare program is entitled to receive notice orally and in writing of the rights and services to which the resident is entitled during the resident's stay in the facility.[1] The notice must be given prior to or upon admission and periodically during the resident's stay, and must be in a language that the resident understands.[2] The resident must acknowledge, in writing, receipt of the notice and any amendments.[3] The facility must prominently display written information about how to apply for and use Medicare benefits, and how to receive refunds for previous payments covered by the benefits.[4] Other specific matters regarding which the resident is entitled to notice include:

— all rules and regulations governing resident conduct and responsibilities.[5]

— a description of the manner in which the resident's personal funds are protected.[6]

— the right to file a complaint with a state survey and certification agency concerning resident abuse or neglect, or misappropriation of resident property.[7]

— the right to be fully informed of the beneficiary's total health status, including, but not limited to, the beneficiary's medical condition,[8] and about care and treatment.[9]

— services available in the facility, and charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.[10]

— the name, specialty, and way of contacting the physician responsible for the resident's care.[11]

Notice of Rights and Services Notification of Change

A resident in a skilled nursing facility which participates in the Medicare program has the right to be fully informed in advance of any changes in care or treatment that may affect the resident's well-being.[1] Accordingly, 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 need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment.[2] The resident and any known legal representative or interested family member must also be promptly notified where there is a change in the resident's room or roommate assignment, or a change in resident rights.[3]

Exercise of Rights

Each resident in a skilled nursing facility which participates in the Medicare program is entitled to exercise the rights as a resident of the facility and as a citizen or resident of the United States free of interference, coercion, discrimination, or reprisal from the facility.[1] Rights of a resident who has been adjudged incompetent under state law may be exercised by the person appointed under state law to act on the resident's behalf.[2]

PRIVACY AND CONFIDENTIALITY – PERSONAL AND CLINICAL RECORDS

A resident in a skilled nursing facility has a right to confidentiality of the resident's personal and clinical records.[1] The resident may approve or refuse the release of the records to any individual outside the facility,[2] except that the resident's right to refuse the release of records does not apply when the resident is transferred to another health care institution, or the release is required by law or a third-party payment contract.[3] The resident has a right to inspect and purchase photocopies of the records upon written request.[4]

Observation:

The resident's clinical record should contain sufficient information to identify the resident, a record of the resident's assessments,[5] the resident's care plan,[6] services provided to the resident, progress notes, and the results of any preadmission screening conducted by a state.[7] The skilled nursing facility is obligated to safeguard clinical records information against loss, destruction, or unauthorized use,[8] and to retain the records for five years from the date of discharge unless some other time period is required by state law, except that records for a minor must be retained for three years after the minor reaches legal age under state law.[9]

PRIVACY AND CONFIDENTIALITY

A resident in a skilled nursing facility which participates in the Medicare program has the right to personal privacy in accommodations, medical treatment, written and telephonic communications, visits, meetings of resident and family groups,[1] and personal care.[2] The right of privacy includes the right to send and receive mail promptly and unopened; to have access to stationery, postage, and writing implements, at the resident's own expense;[3] and to have regular access to the private use of a telephone,[4] but does not require the provision of a private room.[5]

MARRIED COUPLES

Married residents who reside in the same skilled nursing facility which participates in the Medicare program have the right to share a room if both spouses consent to the arrangement.[1]

PARTICIPATION IN GROUPS AND ACTIVITIES

A resident in a skilled nursing facility which participates in the Medicare program has the right to organize and participate in resident groups in the facility,[1] and to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.[2] The family of a resident has the right to meet in the facility with the families of other residents.[3]

The facility must provide any resident or family group with private space;[4] must provide a designated staff person responsible for providing assistance to the group and responding to any written request resulting from a group meeting;[5] and must listen to the views, and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.[6] Staff or visitors may attend group meetings at the group's invitation.[7]

Residents are entitled to have an ongoing activities program provided by the facility.[8] The program must be designed to meet the interests and the physical, mental, and psychosocial well-being of each resident, and must be directed by a qualified therapeutic recreation specialist.[9]

ACCESS AND VISITATION

A resident in a skilled nursing facility which participates in the Medicare program has the right of communication with and access to persons and services inside and outside the facility,[1] to interact with members of the community both inside and outside the facility,[2] to receive information from agencies acting as client advocates, and to be afforded the opportunity to contact these agencies.[3] Immediate access must be allowed by the facility to any resident[4] by:

(1) any representative of the Secretary of Health and Human Services;

(2) any state representative;

(3) the resident's individual physician;

(4) the state long-term care ombudsman established under the Older Americans Act of 1965 (42 U.S.C.A. § 3027(a)(9));

(5) 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;

(6) the agency responsible for the protection and advocacy system for mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act;[5]

(7) the resident's immediate family and other relatives; and

(8) any other person visiting with the consent of the resident.

At any time, the resident has the right to deny or withdraw consent to access by the immediate family, relatives,[6] other visitors,[7] and any entity or individual providing health, social, legal, or other services to the resident, which otherwise must be provided with reasonable access to the resident.[8] With the permission of the resident or the resident's legal representative, representatives of the state ombudsman must be allowed to examine a resident's clinical records, consistent with state law.[9]

ENVIRONMENT

A resident in a skilled nursing facility which participates in the Medicare program has the right to a safe, clean, comfortable, and homelike environment.[1] The resident is entitled to:

(1) a facility designed, constructed, equipped, and maintained to protect health and safety;[2]

(2) a safe, clean, comfortable, and homelike environment;[3]

(3) housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;[4]

(4) an infection control program to help prevent the development and transmission of disease and infection;[5]

(5) clean bed and bath linens that are in good condition;[6]

(6) adequate and comfortable lighting levels in all areas;[7]

(7) comfortable and safe temperature levels (for facilities initially certified after January 1, 1990, the facility must maintain a temperature between 71 and 81 degrees Fahrenheit);[8]

(8) the maintenance of comfortable sound levels;[9]

(9) a room designed and equipped for adequate nursing care, comfort, and privacy;[10]

(10) the use of personal belongings to the extent possible,[11] including some furnishings, and appropriate clothing, as space permits, unless the rights or health and safety of other residents would be infringed;[12] and

(11) private closet space in the resident's room.[13]

ACCOMMODATION OF NEEDS

A resident in a skilled nursing facility which participates in the Medicare program has the right to reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the resident or other residents would be endangered, and to receive notice before the resident's room or roommate in the facility is changed.[1]

FREE CHOICE

A resident in a skilled nursing facility which participates in the Medicare program has the right to self-determination,[1] including the right to choose activities, schedules, and health care consistent with the resident's interests, assessments, and care plan;[2] to make choices about aspects of life in the facility that are significant to the resident;[3] to choose a personal attending physician; and, unless adjudged incompetent or otherwise found to be incapacitated under state law, to participate in planning or changing care and treatment.[4] The resident also has the right to self-administer drugs, unless the facility's interdisciplinary team[5] has determined that this practice is unsafe for the resident,[6] to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive.[7]

GENERALLY

Each resident in a skilled nursing facility which participates in the Medicare program is entitled to a dignified existence,[1] and to be cared for in an environment that promotes the maintenance or enhancement of the resident's quality of life.[2] The facility must promote care that maintains or enhances each resident's dignity and respect in full recognition of the resident's individuality;[3] must provide medically related social services to allow each resident to attain or maintain the highest practicable physical, mental, or psychosocial well-being;[4] and must provide an ongoing activities program.[5]

Work

A resident in a skilled nursing facility which participates in the Medicare program has the right to refuse to perform services for the facility, but may choose to perform services for the facility if:

(1) the facility has documented the need or desire for work in the resident's plan of care;

(2) the plan specifies the nature of the services, and whether the services are voluntary or paid;

(3) compensation for paid work is at or above prevailing rates; and

(4) the resident agrees to the work arrangement described in the plan.[1]

OTHER SPECIAL NEEDS

Each resident in a skilled nursing facility which participates in the Medicare program is entitled to receive from the facility proper treatment and care for special services, which include injection; parenteral and enteral fluids; colostomy, ureterostomy, or ileostomy care; tracheostomy care; tracheal suctioning; respiratory care; and prostheses.[1]

VISION AND HEARING SERVICES

To insure that residents in a skilled nursing facility which participates in the Medicare program receive proper treatment and assistive devices to maintain vision and hearing abilities, the resident must be assisted by the facility, if necessary, in making appointments and arranging for transportation to and from the office of a medical practitioner specializing in the treatment of vision or hearing impairments, or a professional specializing in the provision of vision or hearing assistive devices.[1]

URINARY INCONTINENCE

Based on the comprehensive assessment[1] required for each resident in a skilled nursing facility which participates in the Medicare program, the facility must insure that a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections, and to restore as much normal bladder functioning as possible, and that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization is necessary.[2]

RANGE OF MOTION

Based on the comprehensive assessment[1] required for each resident in a skilled nursing facility which participates in the Medicare program, the facility must insure that a resident whose range of motion is not limited does not experience a reduced range of motion, other than one which the resident's clinical condition demonstrates to be unavoidable, and that a resident whose range of motion is limited receives appropriate treatment and services to increase the beneficiary's range of motion, to prevent any further decrease, or both.[2]

PSYCHOSOCIAL FUNCTIONING

Based on the comprehensive assessment[1] required for each resident in a skilled nursing facility which participates in the Medicare program, the facility must insure that a resident who displays psychosocial adjustment difficulty receives appropriate treatment and services to achieve as much remotivation and reorientation as possible, and that a resident whose assessment does not reveal a psychosocial adjustment difficulty does not display a pattern of decreased social interaction, or withdrawn, angry, or depressive behavior, unless the resident's clinical condition demonstrates that the pattern is unavoidable.[2]

PRESSURE SORES

Based on the comprehensive assessment[1] required for each resident in a skilled nursing facility which participates in the Medicare program, the facility must insure that a resident who enters the facility without pressure sores does not develop pressure sores unless the resident's clinical condition demonstrates that they are unavoidable, and a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from forming.[2]

NUTRITION AND HYDRATION

Based on the comprehensive assessment[1] required for each resident in a skilled nursing facility which participates in the Medicare program, the resident is entitled to receive services from the facility to insure that the resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible, and receives a therapeutic diet when there is a nutritional problem.[2] Each resident is entitled to a nourishing, palatable, well-balanced diet that meets the resident's nutritional and special dietary needs,[3] and to sufficient fluid intake to maintain proper hydration and health.[4] The resident is entitled to receive at least three meals daily, at regular times comparable to normal mealtimes in the community, and a daily snack at bedtime.[5] The resident cannot be required to wait more than 14 hours between a substantial evening meal and breakfast the following day, unless the resident is provided with a nourishing bedtime snack and agrees to an interval of up to 16 hours.[6]

The facility must insure that a resident who has been able to eat enough, alone or with assistance, is not fed by a naso-gastric tube unless the resident's clinical condition demonstrates that use of a naso-gastric tube is unavoidable, and that a resident who is fed by a naso-gastric or gastronomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers, and to restore, if possible, normal feeding function.[7]

MEDICATION

Each resident in a skilled nursing facility which participates in the Medicare program is entitled to receive services from the facility to insure that the resident is free of any significant medication error.[1] The resident's drug regimen must be free from unnecessary drugs,[2] and must be reviewed at least once a month by a licensed pharmacist.[3]

A resident who has not received antipsychotic drugs is not to be given them unless necessary to treat a specific condition.[4] A resident receiving antipsychotic drugs is entitled to receive gradual dose reductions, drug holidays, or behavioral programming in an effort to discontinue the drugs, unless clinically contraindicated.[5]

ACTIVITIES OF DAILY LIVING

Each resident in a skilled nursing facility which participates in the Medicare program is entitled to receive services, based on a comprehensive assessment[1] of the resident, insuring that the resident's ability to perform activities of daily living does not diminish, unless the resident's clinical condition demonstrates that diminution is unavoidable.[2] Activities of daily living include bathing, dressing, and grooming; transferring and ambulating; toileting; eating; and using speech, language, or other functional communication systems.[3] The facility must insure that each resident is given the appropriate treatment and services to maintain or improve the beneficiary's ability to perform these activities,[4] and that any resident who is unable to carry out these activities receives the services which are necessary for the maintenance of good nutrition, grooming, and personal and oral hygiene.[5]

EQUAL ACCESS TO QUALITY CARE

All residents in a participating skilled nursing facility have a right of equal access to quality care.[1] The right of equal access means that identical policies and practices regarding covered services, transfer, and discharge apply to each resident regardless of the source of payment.[2]

GENERALLY

Each resident in a skilled nursing facility which participates in the Medicare program is entitled to receive from the facility the services necessary to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the resident's care plan.[1] The resident is entitled to remain under the care of a physician,[2] who must see the resident at least once every 30 days for the first 90 days after admission, and at least once every 60 days after that, provided that, after the initial visit, the physician may choose to alternate between personal visits and delegated visits by a nurse assistant or practitioner.[3] Other care services to which the resident is entitled include:

(1) nursing services;[4]

(2) specialized rehabilitative services;[5]

(3) pharmaceutical services;[6]

(4) dietary services;[7]

Transfer and Discharge

Each resident in a skilled nursing facility which participates in the Medicare program must be permitted to remain in the facility, and may not be transferred or discharged unless:

- the transfer or discharge is necessary to meet the resident's welfare[1]
- the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility[2]
- the health[3] or safety[4] of individuals in the facility is endangered
- the resident fails, after reasonable and appropriate notice, to pay, or have paid for a stay at the facility[5]
- the facility ceases to operate[6]

The basis of any transfer or discharge, other than one due to cessation of operation of the facility, is required to be documented in the resident's clinical record.[7] The documentation must be by a physician if the transfer or discharge is based on danger to the health or safety of individuals in the facility, and by the resident's physician if based on the resident's welfare or improved health.[8]

The resident is entitled to receive from the facility sufficient preparation and orientation to insure that the transfer or discharge is safe and orderly.[9]

Transfer and Discharge Notice of Appeal

A resident of a skilled nursing facility which participates in the Medicare program and, if known, a family member or legal representative of the resident are entitled to notice before the facility transfers or discharges the resident.[1] Notice may be given as soon as practicable when the resident has not resided in the facility for 30 days, or the basis for the transfer or discharge is danger to the health or safety of individuals in the facility, or urgent medical needs or improved health of the resident.[2] In any other case, notice must be given 30 days before the transfer or discharge.[3]

The notice must include the reasons for the transfer or discharge.[4] The notice must also include a statement regarding the resident's right to appeal the transfer or discharge, and the name, address, and telephone number of the resident's state long-term care ombudsman.[5]

Any resident whose transfer or discharge from a skilled nursing facility is effected on or after October 1, 1989, may appeal through a fair hearing mechanism established by the state with oversight responsibility for the facility.[6]

The fair hearing mechanism must meet guidelines established by the Secretary of Health and Human Services; however, the failure of the Secretary to establish guidelines does not relieve any state of its responsibility to provide for the mechanism.[7]

Discharge Summary

A resident of a skilled nursing facility that participates in the Medicare program whose discharge is anticipated must have a discharge summary that includes a recapitulation of the resident's stay in the facility; a final summary of the resident's status at the time of discharge including information required to be included in the resident's comprehensive assessment,[1] that is available for release to authorized persons and agencies with the consent of the resident, or the resident's legal representative; and a postdischarge plan of care[2] developed with the participation of the resident and the resident's family to assist the resident in adjusting to the resident's new living environment.[3]

Notice that Discharge or Stay is not medically necessary

CMS policy requires that written notice be given by a skilled nursing facility to a Medicare beneficiary when the facility's utilization review committee has made a final finding, upon a utilization review applicable to Medicare beneficiaries, that an admission or further inpatient stay is not medically necessary.[1] According to the policy, the notice, which must also be given to the resident's attending physician, the facility, and, if appropriate, the resident's next of kin, must be given no later than three working days after the review date except that where the finding is made before a continued stay review date, the notice must be given no later than two days after the decision is made.[2] While the attending physician may advise the beneficiary personally of the utilization review committee's finding, the committee must also give timely notice of its decision to the beneficiary, or, where appropriate, the next of kin.[3]

The beneficiary or family is also entitled under the policy to be given advance notice if the facility's utilization review committee is going to review whether there is a continuing need for a skilled level of care.[4] The policy requires that the notice contain the name of any physician with whom the facility intends to consult; a statement that the facility is required to provide the resident's attending physician with an opportunity to present the beneficiary's views; and, in the case of a final committee finding, a statement that a committee finding is not a federal decision about Medicare payment, and that a final claims determination will be made when the facility submits a claim to a CMS intermediary.[5] The resident or family is entitled to receive a separate notice from the intermediary, and, if there is a claims denial, a notice of appeal rights.[6]