

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, or account for the resident's funds (for example, losses occurring as a result of acts or errors of negligence, incompetence, or dishonesty). The surety bond protects the resident or the State, not the facility, from loss. It 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 that the facility will hold, safeguard, manage and account for the personal funds residents have deposited with the facility. The facility assumes the responsibility to compensate the resident or the State for the amount of the loss up to the entire amount of the surety bond.

The surety bond is not limited to personal needs allowance funds. Any resident funds that are entrusted to the facility for a resident must be covered by the surety bond, including refundable deposit fees.

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(f)(10)(vi)**

Through interviews with residents or their representative, determine if they were compensated for losses occurring from any failure by facility staff to hold, safeguard, manage, or account for the residents' funds (for example, losses occurring as a result of acts or errors of negligence, incompetence, or dishonesty). If concerns arise based on these interviews, review the facility's records to determine whether these concerns are substantiated.

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 these requirements, 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 that 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.

#### **F571**

**(Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)**

**§483.10(f)(11) The facility must not impose a charge against the personal funds of a resident for any item or service 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 of this chapter, 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 must not charge a resident for the following categories of items and services:
  - (A) Nursing services as required at §483.35.
  - (B) Food and Nutrition services as required at §483.60.
  - (C) An activities program as required at §483.24(c).
  - (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 assistance, and basic personal laundry.
  - (F) Medically-related social services as required at §483.40(d).
  - (G) Hospice services elected by the resident and paid for under the Medicare Hospice Benefit or paid for by Medicaid under a state plan.
- (ii) Items and services that may be charged to residents' funds. Paragraphs (f)(11)(ii)(A) through (L) of this section 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 they are not required to achieve the goals stated in the resident's care plan, if the facility informs the resident that there will be a charge, and if payment is not made by Medicare or Medicaid:
  - (A) Telephone, including a cellular phone.
  - (B) Television/radio, personal computer or other electronic device 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.
  - (F) Gifts purchased on behalf of a resident.
  - (H) Flowers and plants.
  - (I) Cost to participate in social events and entertainment outside the scope of the activities program, provided under §483.24(c).
  - (J) Non-covered special care services such as privately hired nurses or aides.
  - (K) Private room, except when therapeutically required (for example, isolation for infection control).

**(L) Except as provided in (e)(11)(ii)(L)(1) and (2) of this section, specially prepared or alternative food requested instead of the food and meals generally prepared by the facility, as required by §483.60.**

**(1) The facility may not charge for special foods and meals, including medically prescribed dietary supplements, ordered by the resident's physician, physician assistant, nurse practitioner, or clinical nurse specialist, as these are included per §483.60.**

**(2) In accordance with §483.60(c) through (f), when preparing foods and meals, a facility must take into consideration residents' needs and preferences and the overall cultural and religious make-up of the facility's population.**

**(iii) Requests for items and services.**

**(A) The facility can only charge a resident for any non-covered item or service if such item or service is specifically requested by the resident.**

**(B) The facility must not require a resident to request any item or service as a condition of admission or continued stay.**

**(C) The facility must inform, orally and in writing, the resident 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.**

#### **GUIDANCE §483.10(f)(11)**

Residents must not be charged for universal items such as computers, telephones, television services or other electronic devices, books, magazines or newspaper subscriptions intended for use by all residents.

#### **PROCEDURES §483.10(f)(11)**

During interviews with residents or their representatives determine:

- How and when they were notified by facility staff regarding the items and services that may not be covered during their stay at the facility.
- Whether or not they may have been charged for items or services they believed were covered by the facility or their insurer. If concerns are raised review a resident's billing statements to determine if they were charged for covered items or services. If charges found on these 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.
- How and when they were informed of any items or services that would be charged to them before these items or services are provided.

#### **KEY ELEMENTS OF NONCOMPLIANCE §483.10(f)(11)**

To cite deficient practice at F571, the surveyor's investigation will generally show that the facility failed to do one or more of the following:

- Made a charge against the resident's personal funds for:
  - Any item or service covered under Medicare or Medicaid (except for applicable deductible or coinsurance amounts); **or**
  - Charged a resident for an item or services not required to achieve the goal stated in the resident's care plan, without notifying the resident of the charge; **or**