

20 Common Nursing Home Problems - and How To Resolve Them

By Eric Carlson

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Introduction

The average consumer knows much more about cars (or apartments, or cell phones) than she knows about nursing homes. What if, for example, an apartment tenant is told by her landlord that she has to move out within 48 hours, because she is too “difficult”? The tenant likely will object, and the law will be on her side in most cases, assuming that the rent has been paid.

As is explained in the discussion of Problem #19, being “difficult” never is enough to justify eviction from a nursing home, and evictions from nursing homes generally require 30-day advance notice. These eviction rules are set by the federal Nursing Home Reform Law, and they apply across the country.

Unfortunately, however, if a nursing home resident is told by the nursing home that she must leave within 48 hours on account of being “difficult,” the resident may panic and move out. Because she is unfamiliar with the relevant law, she is inclined to automatically believe everything told to her by the nursing home.

Too frequently, nursing homes follow standard operating procedures that violate the Nursing Home Reform Law and are harmful to residents. This guide discusses some of the most common practices, which are actually illegal, and explains strategies that residents and family members can use to avoid or reverse these illegal procedures. The goal is for each resident to receive the best care possible in full accordance with the law.

Important Note

This guide is not a substitute for the independent judgment and skills of an attorney or other professional. If you require legal or other expert advice, please consult a competent professional in your geographic area.

The Nursing Home Reform Law, referred to above, applies to every nursing home that is certified to accept payment from the Medicare or Medicaid programs (or both), even if the resident involved is not eligible for either program and as a result is paying privately. Because Medicare and Medicaid are important sources of payment, over 95 percent of nursing homes are governed by the Reform Law.

The Reform Law's cornerstone is the requirement that each nursing home provide the care that a resident needs to reach his or her highest practicable level of functioning. (See Section 483.25 of Title 42 of the Code of Federal Regulations) Some residents are capable of gaining strength and function; other residents are capable of maintaining their current condition. Still other residents at most may be able to moderate their level of decline. In all of these situations, the nursing home must provide all necessary care.

In implementing this guide's strategies, a resident or resident's family member at times may benefit from the assistance of an attorney or other advocate. One good source of assistance is the long-term care ombudsman program. Each state has

an ombudsman program that provides advocacy for nursing home residents free of charge. Contact information for a particular state's ombudsman program can be found at the website of the National Long Term Care Ombudsman Resource Center at www.ltombudsman.org.

Each state maintains an inspection agency (often part of the state's Health Department) that is responsible for monitoring nursing homes' compliance with the Reform Law, certifying nursing homes for participation in Medicare and Medicaid, and issuing state licenses. Each of these agencies will investigate in response to a consumer complaint, and can issue warnings or impose penalties to force a nursing home to fix a particular violation.

The National Consumer Voice for Quality Long-Term Care (www.theconsumervoic.org) has many helpful publications for nursing home residents and their families. The federal government maintains a Nursing Home Compare website (www.medicare.gov/nursinghomecompare/search.html) that provides extensive information on individual nursing homes.

Recommendation: Be a Squeaky Wheel!

Can it really be possible that many nursing homes follow illegal procedures? Regrettably, the answer to this question is an emphatic “yes,” based on the experiences of the author, and of other attorneys and ombudsman program representatives who assist nursing home residents.

The next question is “How?” More specifically, how can it be that so many nursing homes have been allowed to develop standard procedures that violate the Nursing Home Reform Law?

Certainly part of the answer is consumers’ unfamiliarity with nursing homes, specifically with the protections provided by the Reform Law. Another part of the answer is the unwillingness of residents and their family members to make complaints to nursing homes, due to shyness and a fear that a nursing home will retaliate against a resident in some way. Together, this shyness, lack of knowledge, and fear of retaliation allow some nursing homes to develop and follow illegal procedures.

This guide recommends that residents and their families develop a healthy sense of entitlement to high-quality nursing home care. A nursing home is paid thousands of dollars monthly to care for a

resident, and is obligated by the Reform Law to provide individualized care. A resident or family member shouldn’t feel sheepish to ask (for example) that necessary therapy be provided, or that a resident be allowed to sleep as long as she wants in the morning.

While a resident or family member may be afraid of retaliation, that risk is small, particularly when compared to the risk of being passive. Nursing home employees generally have no reason or inclination to retaliate. Complaints usually are made to a nursing home’s nurses and administrators, but most day-to-day care is provided by nurse aides. In any case, the issues covered in this guide are, in most instances, focused on nursing home policy and are not directed against a particular employee.

As the cliché counsels, the squeaky wheel gets the grease. If a resident and family are too afraid or shy to ask for anything, the resident almost assuredly will get relatively little attention. If, however, a resident and family are determined (but generally polite) in asking for individualized care, and are appropriately friendly and appreciative, the resident will tend to receive more attention and better care.

A Brief Introduction to Medicare & Medicaid

Eligibility

Under both the Medicare and Medicaid programs, an adult beneficiary generally must be at least 65 years old, or disabled. For Medicare coverage, the beneficiary or beneficiary's spouse usually must have made certain contributions through payroll deductions to the Social Security program. A beneficiary's income and resources do not matter. In general, Medicare coverage can be thought of as a health insurance policy purchased through premiums deducted from payroll checks.

Under the Medicaid program, a beneficiary need not have contributed to the Social Security program, but must have limited resources and income. Medicaid money comes from both federal and state governments; as a result, some Medicaid rules vary from state to state. The Medicaid program can be thought of as a safety-net health care program provided by the federal and state governments for persons who otherwise have inadequate resources to pay medical bills.

Payment for Nursing Home Care

The Medicare and Medicaid programs differ in the way that they pay for nursing home care. Because the Medicaid program is (as described above) a safety-net source of payment for individuals who have no other options, Medicaid will pay indefinitely for nursing home care, assuming that the resident remains financially eligible and continues to need nursing home care.

Under Medicaid, the resident might have to pay a monthly deductible, depending on the resident's income and (in some cases) the income of the resident's spouse. The name of this monthly deductible varies from state to state – for example, “patient pay amount,” “share of cost,” or “Medicaid co-payment.” This guide will use the term “patient pay amount.”

The Medicare program, by contrast, pays for nursing home care for a very limited period of time. At most, Medicare will pay for only 100 days of nursing home care per benefit period. A new benefit period starts when the Medicare beneficiary for at least 60 days has not received Medicare-covered inpatient care in the nursing home or in a hospital.

Of those 100 days, only the first 20 days are paid in full. For days 21 through 100, the beneficiary must pay a daily co-payment of \$157.50 (for 2015). Many Medicare Supplement insurance policies (commonly called “Medigap” policies) will cover this co-payment.

The Medicare program can pay for nursing home care only if the resident is entering the nursing home within 30 days after a hospital stay of at least three nights. The need for nursing home care must be related to the medical care received in the hospital.

Finally – and this is the biggest limitation of all – Medicare payment for nursing home care is only available if the resident requires skilled nursing services or skilled rehabilitation services on a daily or almost-daily basis. The need for these skilled services is discussed in considerable detail during this guide's discussions of Problems #11 and #12.

#1 Discrimination Against Medicaid-Eligible Residents

What You Hear: ✘ *“Medicaid does not pay for the service that you want.”*

The Facts: ☑ A Medicaid-eligible resident is entitled to the same level of service provided to any other nursing home resident.

The Nursing Home Reform Law prohibits discrimination based on a resident’s Medicaid eligibility. A nursing home “must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services required under the State [Medicaid] plan for all individuals **regardless of source of payment.**” (Section 483.12(c)(1) of Title 42 of the Code of Federal Regulations [emphasis added])

Nursing homes have a love-hate financial relationship with Medicaid. On one hand, approximately two-thirds of nursing home residents are Medicaid-eligible, and the Medicaid program accounts for approximately one-half of nursing homes’ total revenues. On the other hand, Medicaid rates tend to be the lowest – lower than private-pay rates, and much lower than the rates paid by the Medicare program.

What to Do to Fight Medicaid Discrimination

A Medicaid-eligible resident should resist any attempt by the nursing home to give

her second-class treatment. She should emphasize the federal law (quoted above) that prohibits a nursing home from discriminating against Medicaid-eligible residents.

Nursing home staff members are quick to claim – generally without proof – that the nursing home loses money on each Medicaid-eligible resident. A resident should avoid getting drawn into a discussion of the nursing home’s financial status. There is no way to win the argument without a detailed audit of the nursing home and any related corporations.

A better strategy is to assume that the nursing home’s finances are irrelevant as, indeed, they are in this situation. By seeking Medicaid certification, a nursing home promises the federal and state governments that it will provide Medicaid-eligible residents with the care guaranteed by the Nursing Home Reform Law. It is completely hypocritical for the nursing home to accept Medicaid money for a resident’s care, and then turn around and tell the resident that the care will be inadequate because Medicaid payment rates are low.

If a nursing home feels that Medicaid rates truly are too low, then it should cancel its Medicaid certification. Otherwise, the

nursing home should provide Medicaid-eligible residents with the high-quality care required by the Nursing Home Reform Law.

Problems #2–7: Substandard or Inappropriate Care

#2 Failing to Take Care Planning Seriously

What You Hear: ✘ *“The nursing staff will determine the care that you receive.”*

The Facts: ✔ **The resident and resident’s family have the right to participate in developing the resident’s care plan.**

A nursing home must complete a full assessment of a resident’s condition within 14 days after admission, and thereafter at least once every 12 months and after a significant change in the resident’s condition. More limited assessments must be done at least once every three months. Assessments use a standardized document called the Minimum Data Set (“MDS”).

Assessments are used for development of a comprehensive care plan, which must be prepared initially within seven days after completion of the first full assessment. Every three months, care plans must be reviewed and, if necessary, revised. Also, a care plan can be reviewed and revised at any time as necessary.

The care plan is prepared by a team that includes the resident’s doctor, a registered nurse, and other appropriate nursing home staff members. Most importantly, the team should include the resident, the resident’s legal representative, and/or a member of the resident’s family. (See Section 483.20(k)(2) of Title 42 of the Code of Federal Regula-

tions) The nursing home staff is required to schedule care plan meetings at a time that allows others to attend.

What to Do to Ensure a Good Care Plan

The resident or family member should attend all care plan meetings. (In this discussion, “family member” includes the resident’s legal representative.) If the nursing home fails to give notice of the meetings, the resident or family member should ask when the meetings are being held, and request to be included.

Care planning should be taken seriously. An individualized care plan can be an invaluable tool to improve the care provided to a resident.

Prior to a care plan meeting, the resident or family member should think creatively about what the resident might want or appreciate. There is no reason to be timid. A nursing home is paid thousands of

dollars monthly to care for a resident, and should be expected to provide personalized care. Also, the Reform Law requires that a nursing home address a resident's particular needs and preferences. (See Problem #3 for more information.)

Some nursing homes treat care plans as a meaningless formality, resulting in care plans that are almost identical from one resident to the next. This is a great waste of the care planning process. To be meaningful, a care plan truly should address individual needs and preferences.

A resident or family member often feels intimidated by care planning meetings. "Who am I," a family member might think, "to tell a nurse what should be done for my dad in a nursing home?" The sense of intimidation or shyness is only intensified by the fact that, in a care plan meeting, a resident or family member is likely to be outnumbered by nursing home staff members.

The resident or family member should resist any sense of intimidation. In most cases, care planning decisions do not involve

complicated medical issues. Instead, the optimal plan of care is relatively obvious, and the issue is whether or not the nursing home will commit to providing that type of care.

So, the resident or family member should not feel limited to a one-size-fits-all care plan presented by the nursing home. The resident or family member should think of what the resident needs or prefers, and ask that that service be written into the care plan.

Once the care plan is in place, the resident or family member can use it as needed to assure that the resident receives the best possible care. Assume for example that the care plan calls for the resident to be walked around the block daily, but the nursing home fails to make a staff member available to assist the resident. In such a case, the resident or family member can point to the care plan as a requirement that the nursing home provide the resident with the necessary assistance.

#3 Disregarding Resident Preferences

- What You Hear: ❌ *“We don’t have enough staff to accommodate individual schedules. You must wake up every morning at 6 a.m.”*
- ❌ *“Because of our scheduling, your bath always will be at 2 p.m.”*
- ❌ *“If you don’t like the meal entrée, your only option is a peanut butter sandwich.”*

The Facts: **A nursing home must make reasonable adjustments to honor resident needs and preferences.**

Freedom of choice is a vital part of a resident’s quality of life. A nursing home should feel like a home rather than a health care assembly line.

Accordingly, the Nursing Home Reform Law requires a nursing home to make reasonable adjustments to meet resident needs and preferences. For example, a resident has the right to “[c]hoose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care.” (Section 483.15(b)(1) of Title 42 of the Code of Federal Regulations)

The resident or resident’s representative should not feel bound by a nursing home’s standard operating procedures. It does not necessarily matter that up to now the nursing home never has allowed residents to sleep past 6 a.m., or has refused to serve Chinese food (for example). If a requested change in procedure is reasonable, the nursing home must make the change.

Of course, the \$64 million question is

“What is reasonable?” but this question has no scientific answer. Because the definition of “reasonable” is not precise, residents and family members must be prepared to explain why the benefit from a proposed change is worth whatever inconvenience or expense may be involved.

More enlightened nursing homes are realizing the benefits – both to residents and to the nursing homes – of giving more control to residents and to individual staff members. The goal is to change the culture of nursing homes so that care is more “resident centered.” By implementing this “culture change,” nursing homes across the country have improved resident care and customer satisfaction, and have done so while making a profit. The message to nursing homes is: “Good care is good business.”

Helpful information about nursing home culture change and resident-centered care is available from the Pioneer Network, www.pioneernetwork.net.

What to Do to Have Resident Preferences Honored

As is true throughout the problems discussed in this guide, a resident or resident's representative should not be hesitant about making a request to the nursing home. The nursing home is paid to care for each resident, and there are legal and moral reasons why each resident is entitled to be treated as an individual human being.

Letting a resident sleep past 6 a.m. is easily supportable, because most observers would understand why an adult would not want to be awakened every single day at the crack of dawn. The nursing home could adjust its nurse aide schedules or, if necessary, increase its nurse aide staffing. A very late-waking resident could

be served cereal and fruit rather than a hot breakfast.

In requesting a change, the resident or resident's representative should explain why the change would be good for the resident, and why the law requires such a change. A follow-up letter is helpful, as is a copy of this guide. Oftentimes, the request for a change can be made in a care planning meeting.

A resident council or family council (see Problem #18) can be a good place in which to organize support for a change in a nursing home's procedures, and specifically for care that is more resident centered. There is strength in numbers: if an entire group of residents and/or family members is pushing for a particular action, the nursing home is much more likely to give in.

#4 Failing to Provide Necessary Services

What You Hear: ✘ *"We don't have enough staff. You should hire your own private-duty aide."*

The Facts: ✔ **A nursing home must provide all necessary care.**

The foundation of the Nursing Home Reform Law is the previously discussed requirement that each nursing home provide the care that a resident needs to reach the highest practicable level of functioning. (See Section 483.25 of Title 42 of the Code of Federal Regulations) Obviously, that requirement is being violated if the nursing home is expecting or encouraging the hiring of private-duty aides.

What to Do to Ensure All Necessary Services Are Being Provided

The resident or family member should make clear that it is the nursing home's legal responsibility to provide necessary care, and that a claimed shortage of staff or money is no excuse. The specific request should be made in writing and, if necessary, the relevant law and/or a copy

of this guide can be included as support. The need for the specific care might be shown by such documents as a doctor's order, the assessment, and/or the care plan.

If the nursing home continues to refuse to provide necessary care, a complaint can

be made to the state inspection agency (see *Introduction*). Other options include raising the issue at a resident or family council meeting (see Problem #18), seeking assistance from the long-term care ombudsman program (see *Introduction*), or consulting with an attorney.

#5 Improper Use of Physical Restraints

What You Hear: ✘ *“If we don't tie your father into his chair he may fall or wander away from the nursing home. There's just no way we can always be watching him.”*

The Facts: ✔ **Physical restraints cannot be used for the nursing home's convenience or as a form of discipline.**

A physical restraint is a device that restricts a resident's freedom of movement. Perhaps the most common physical restraint is a vest or belt that ties the resident into his wheelchair or bed. A seat belt is a physical restraint, as is a chair that is angled back to prevent the resident from standing up. Bed rails are another common type of physical restraint.

Under the Nursing Home Reform Law, a physical restraint can be utilized only to treat a resident's medical conditions or symptoms. Restraints never can be used for discipline or the nursing home's convenience. (See Section 483.13(a) of Title 42 of the Code of Federal Regulations)

The use of physical restraints has dropped drastically over the past twenty years and many nursing homes now function completely restraint-free. Part of this decline certainly is due to the Reform Law's restriction on the use of physical restraints.

Another part of the decline is due to a growing medical consensus that, instead of protecting residents, the use of restraints is harmful, both physically and psychologically. By limiting a resident's ability to move, restraints may cause a resident to become ever more unsteady, and more susceptible to falls and injuries. Some residents are asphyxiated and die after becoming tangled up in restraints. Psychological consequences can be equally devastating.

Like any type of medical intervention, physical restraints can be used only with the consent of the resident or, if the resident does not have the mental capacity to consent, the resident's representative. If the use of restraints is recommended by the resident's doctor, the resident or resident's representative has the choice whether to accept or reject that recommendation, but that choice should be made with knowledge of restraints' negative consequences. The nursing home must suggest less restrictive

methods of managing the problem for which restraints are being recommended.

What to Do to Limit Use of Restraints

If the nursing home recommends restraints to prevent the resident from wandering, the resident's representative should just say no. First, of course, the use of restraints requires an order from the resident's doctor, not just a recommendation from the nursing home. Also, in this case the use of restraints evidently is being proposed solely for the nursing home's convenience. Instead of imposing restraints, the nursing home should explore options such as increasing staffing levels, installing an electronic monitoring system, or having meaningful activities available to combat boredom and use up excess energy.

What if a resident's doctor proposes a restraint to prevent the resident from falling – for example, a vest restraint proposed to prevent the resident from slipping from his wheelchair? Although the restraint likely will be presented as a means of preventing falls and injuries, it is important to keep in mind that the restraint instead may cause the resident to become weaker and more vulnerable to injury. In addition, the experience of being tied to a chair may tend to

make the resident agitated or depressed. In a worst-case scenario, the resident becomes so depressed that he is mute, withdrawn, and slumped over. Also, the use of restraints not infrequently leads to injury, as an agitated resident thrashes around in an attempt to free himself. The worst-case scenario of physical injury is that the resident strangles himself while trying to get loose.

Alternatives to restraints always exist, and those alternatives can be effective in protecting residents' health and safety. An alternative to bed rails, for example, is a bed that can be lowered to just a few inches from the floor, along with a padded mat placed next to the bed.

The ultimate decision on the use of restraints rests with the resident or (more likely) the resident's representative, and depends on the facts of the particular situation. In making the decision, the resident's representative should make sure that the use of restraints is a last resort, and should be aware of the considerable research on how the use of restraints can be limited or virtually eliminated.

If and when restraints are recommended, a resident's representative may want to discuss the issues in a care plan meeting. The care planning process is a good opportunity to discuss the pros and cons of restraints, and to examine possible alternatives.

#6 Improper Use of Behavior-Modifying Medication

What You Hear: ✘ *“Your mother needs medication in order to make her more manageable.”*

The Facts: ☑ Medication can be used to modify behavior only when the behavior is caused by a diagnosed illness for which a specific medication is needed for the resident’s treatment.

Under the Reform Law, a behavior-modifying medication – also called a “psycho-active” medication – can be used only to treat a resident’s medical conditions or symptoms. Behavior-modifying medication cannot be used for discipline or the nursing home’s convenience. (See Section 483.13(a) of Title 42 of the Code of Federal Regulations)

Like any other medication, behavior-modifying medication can be administered only with the consent of the resident or – if the resident does not have mental capacity to consent – the resident’s representative. If behavior-modifying medication is recommended by the resident’s doctor, the resident or resident’s representative must be told what condition or illness is being treated, and then has the choice whether to accept or reject the recommendation.

What to Do to Prevent the Inappropriate Use of Behavior-Modifying Medication

It should be noted that behavior-modifying medications can (as appropriate) be used to treat various psychological and

emotional conditions – schizophrenia, paranoia or depression, for example. In deciding whether use of a particular medication is advisable, a good rule of thumb is to consider whether the medication’s use is intended for the resident’s benefit to treat a specifically diagnosed health problem, or is meant for the nursing home’s benefit to keep the resident more manageable. If the benefit is to the resident, then use of the medication is likely to be advisable. If, on the other hand, use of the medication would be solely for the nursing home’s benefit – for example, to keep the resident quiet and out of the way – then the medication likely should be refused.

The most important point with behavior-modifying medications is the right of the resident or (more likely) the resident’s representative to decide whether or not to use them. If a resident’s representative feels that the use of such medication would be unwise, premature, or excessive, he should feel free to say “no.”

A care planning meeting is a good forum in which to discuss issues relating to medication. A resident’s representative should not be coerced into approving a behavior-modifying medication that does not benefit

the resident. If the use of such medication is recommended by the doctor or nursing home staff members, the representative

should ask the doctor or staff members to propose alternatives.

#7 Excessive Use of Feeding Tubes

What You Hear: ✘ *“We must insert a feeding tube into your father because he is taking too long to eat.”*

The Facts: ✔ **The use of a feeding tube should be a last resort.**

Under the Nursing Home Reform Law, a nursing home must assist a resident in maintaining his ability to eat. Staff members should be available in adequate numbers, and be willing to spend the necessary time. As appropriate, residents should be provided with assistive devices to improve grasp and coordination. Also, the eating environment should be calm and pleasant; this is particularly important in the case of residents with dementia.

For a resident unable to take food via mouth, nutrition can be provided through a tube into the stomach. A nasogastric tube enters the stomach through the nose and the nasal passages; a gastrostomy tube enters the stomach directly. The most common gastrostomy is a percutaneous endoscopic gastrostomy, abbreviated PEG. An endoscope gives the physician a close-up view inside the body. A PEG tube is inserted through the stomach wall with the assistance of an endoscope that has entered the stomach through the resident’s throat.

In a study comparing tube feeding with careful hand feeding, it was found that the tube feeding did not increase the length of survival of residents with dementia. In other

research, tube feeding was not shown to reduce the risk of aspiration (inhaling food into the lungs). A further disadvantage of tube feeding is that it often is accompanied by restraint use, to prevent the resident from pulling out the tube.

Tube feeding in a nursing home should be done only if absolutely necessary. The Reform Law’s regulations state: “A resident who has been able to eat enough alone or with assistance is not fed by [a] tube unless the resident’s clinical condition demonstrates that use of a ... tube was unavoidable.” (Section 483.25(g)(1) of Title 42 of the Code of Federal Regulations)

A resident’s slowness in eating is not reason enough for insertion of a feeding tube. Neither is a nursing home’s shortage of staff. It is the nursing home’s responsibility to provide necessary assistance. If necessary, the nursing home should increase its staffing or stagger its mealtimes.

On occasion, a nursing home will claim that it must use tube feeding because otherwise it will be penalized by government inspectors for the resident’s loss of weight. This claim is wrong because (as discussed

above) adequate nutrition generally can be provided even without tube feeding, and because inspectors will not penalize a nursing home for following a treatment choice made by a resident or resident's representative.

What to Do to Limit Use of Feeding Tubes

Because the insertion of a feeding tube is a medical procedure, the insertion cannot be performed without the consent of the resident or – if the resident does not have the mental capacity to consent – the resident's representative. Because lack of mental capacity is common among residents who have difficulty eating, the following discus-

sion presumes that the decision belongs to the resident's representative.

The representative should not hesitate to refuse feeding tube insertion whenever the resident is capable of eating with assistance. As discussed above, the Reform Law requires that feeding tubes be used only as a last resort. Indeed, eating is one of the basic pleasures of life, and a resident's quality of life is likely to be diminished if his meals are replaced by tube-delivered nutrients.

Once again, the care planning process is a good opportunity to address the issues. A resident's representative should work with the care planning team to develop ways in which the resident can eat without need of tube feeding.

#8 Imposing Visiting Hours on Families and Friends

What You Hear: ✘ *“Your children can visit you only during visiting hours.”*

The Facts: ✔ **A resident's family member can visit at any time of the day or night.**

Under the Nursing Home Reform Law, a nursing home should be as homelike as possible. Consistent with this philosophy, a nursing home cannot limit visiting hours for “family members or friends.” (Section 483.10(j)(1) of Title 42 of the Code of Federal Regulations, and accompanying Surveyor's Guidelines) For a late-night visit, federal guidelines suggest that the visit take place outside of the resident's room – in the

nursing home's dining room, for example – to avoid disturbing other residents' sleep.

There are good reasons why a family member or friend might want to visit outside of “normal” visiting hours. The visitor might not get off work until visiting hours are over. Or the resident may have a lifelong habit of staying up late.

In addition, an off-hours visit may give

a family member or friend a better opportunity to check up on a nursing home. A visit at midnight or five in the morning (for example) gives a visitor a good look at how the nursing home handles residents' late-night needs.

Naturally, a visit can only be made if the resident wants the visitor to be there. If a resident does not want to see a visitor, the visitor has no right to visit.

If a resident lacks mental capacity, decisions regarding visitors can be made by the resident's representative. In most cases, the appropriateness of a visit is obvious, because the resident of course wants visits from

family members and friends.

What to Do to Challenge Visiting Hour Restrictions

If a nursing home tells a family member that visits can be made only during official visiting hours, the family member should let the nursing home know that the Reform Law allows a family member or friend to visit at any time. To back up this argument, the family member should give the nursing home a copy of the law (see Section 483.10(j)(1) of Title 42 of the Code of Federal Regulations), the accompanying Surveyor's Guidelines, and/or this guide.

Problems #9–10: Harmful Language in Admission Agreements

#9 Forcing Family Members and Friends to Take on Financial Liability

What You Hear: ✘ *“We can't admit your mother until you sign the admission agreement as a 'Responsible Party.'”*

The Facts: ✔ **A nursing home cannot require anyone but the resident to be financially responsible for nursing home expenses.**

The Nursing Home Reform Law bars a nursing home from requiring a resident's family member or friend to become financially liable for nursing home expenses. (See Section 483.12(d)(2) of Title 42 of the Code of Federal Regulations) The signature of a family member or friend can be required only if the family member or friend is signing on the resident's behalf. For example, it is appropriate for a family member to sign an admission agreement as the resident's appointed agent, because in

that case the financial liability belongs solely to the resident.

This law makes good sense. Nursing homes already are protected if a resident runs out of money: the Medicaid program will pay for residents who otherwise are unable to pay. Also, it is unfair for a nursing home to force a family member or friend to take on an unspecified and potentially huge liability. Unlike a family member who co-signs on a car loan of \$10,000 (for example), a family member who becomes liable

for nursing home expenses might become liable for \$1,000 or \$100,000 (or more), depending on the circumstances.

Over the years, various nursing homes have tried to get around this law. This guide discusses two tactics that nursing homes have used: tricking a family member or friend to “volunteer” to become financially liable, and having the family member or friend sign an agreement to handle the resident’s affairs in a certain way.

“Volunteering” to Become Financially Responsible

Some nursing homes use “Responsible Party” signatures as a way of tricking a family member or friend into becoming financially liable. Usually, the “Responsible Party” signature line does not explain what “Responsible Party” means. As a result, family members are likely to believe that a “Responsible Party” is merely a contact person.

A son or daughter might think: “I should be the ‘Responsible Party’ so that the nursing home will let me know what’s going on. After all, I certainly don’t want to be *irresponsible*.”

What the son or daughter does not realize is that a paragraph in the middle of the admission agreement defines “Responsible Party” as someone who is completely financially liable for nursing home expenses. Generally the definition paragraph claims, falsely, that the “Responsible Party” understands that she is not required to become financially liable for nursing home expenses, but nonetheless is volunteering to take on that liability. This language demonstrate nursing homes’ attempts to evade the Reform Law. As discussed above,

the Reform Law prohibits a nursing home from requiring a family member or friend to become financially liable for nursing home expenses. Nursing homes claim that this prohibition doesn’t apply to “Responsible Party” provisions because (according to the nursing homes) the “Responsible Parties” are volunteering to become financially liable.

The nursing homes’ arguments are wrong: for three reasons, “Responsible Party” provisions are illegal and unenforceable. The first reason is that “Responsible Party” provisions often are used to require guarantees, in direct violation of the Reform Law. In the example at the beginning of this section, the nursing home is requiring the resident’s daughter to sign as “Responsible Party.” Like any other family member or friend, the daughter has no good reason to “volunteer” to become financially liable.

The second reason is that “Responsible Party” provisions are deceptive. Generally a family member or friend believes that a “Responsible Party” is merely a contact person.

The third reason is that neither the resident nor the Responsible Party receives any benefit from the Responsible Party signature. Under general contract rules, a contract is enforceable only if each party to the contract gets a benefit. When a family member or friend signs as a “Responsible Party,” however, only the nursing home benefits. From the point of view of the resident and the “Responsible Party,” the only possible benefit is the resident’s admission, but the Reform Law says that admission decisions can’t depend upon a family member or friend becoming financially liable.

Agreeing in the Admission Agreement to Handle Resident's Affairs in a Certain Way

The nursing homes' other strategy also has the family member or friend sign the admission agreement (probably as a "Responsible Party"), but in this instance the agreement does not claim that he or she is "volunteering." Instead, the agreement has the family member or friend promise that, to the extent he or she has control over the resident's finances, the family member or friend will use the resident's resources to pay for the facility's charges. Also, the family member or friend promises to take all necessary steps to apply for Medicaid eligibility on the resident's behalf, if the resident cannot afford to pay privately.

When a resident's bill is unpaid, a nursing home may rely on an agreement like this to sue the family member or friend for payment. In such a case, the court should reject the nursing home's claim. By suing the family member, the nursing home is trying to get around the federal law that prohibits a nursing home from requiring a family member or friend to take on financial liability. Also, the nursing home is trying to sidestep the standard rule that an agent is not personally responsible for the expenses of the person or business that he or she represents.

In lawsuits brought by nursing homes against family members under these types of provisions, many judges have rejected the nursing home's claims, but other judges have ruled in favor of the nursing home. In the cases won by the nursing home, the family member generally has misappropriated the resident's money for the family member's benefit, leading the judge to rule

against the family member in order to redirect the misappropriated money to where it belongs.

Family members and friends should avoid signing these types of agreements: as explained above, these agreements violate 1) the Nursing Home Reform Law and 2) the standard rule that an agent is not liable for the expenses of the person that he or she represents. A nursing home does not need a "Responsible Party" agreement in order to sue a misappropriator of the resident's funds. The problem with this type of "Responsible Party" agreement is that nursing homes use them not only to proceed against misappropriators, but also to threaten and sue family members and friends who have tried in good faith to help the resident.

What To Do To Challenge 'Responsible Party' Provisions

During Admission: If a family member or friend is being asked to sign as a "Responsible Party," she should not hesitate to refuse, assuming that the resident already has moved physically into her room in the nursing home. Once the resident physically has moved in, there are only six reasons that can cause the resident's eviction (see this guide's discussion of Problem #19), and a refusal by a family member or friend to sign as "Responsible Party" is not one of those six reasons.

If the resident has not moved into the nursing home yet, the situation is a bit more complicated. If the family member or friend refuses to sign as "Responsible Party," the nursing home possibly will refuse admission. In this situation, this guide recommends

that the family member or friend consider refusing to sign as “Responsible Party,” with a polite but firm explanation of why “Responsible Party” provisions are illegal and unenforceable. If the family member or friend is the resident’s agent, the family member or friend can sign for the resident in that capacity, without promising on how the agent will pay the nursing home and/or complete a Medicaid application.

The nursing home staff member probably will be too embarrassed or confused to object, and will continue with the resident’s admission. Of course, there is a risk that the nursing home will refuse admission, but avoiding that risk generally is not worth the signing of an illegal and unfair admission

agreement. Also, refusing to sign is an important step in educating nursing homes and their staff on the inappropriateness of “Responsible Party” provisions.

During or After Resident’s Stay at Nursing Home: What if a family member or friend signed as a “Responsible Party,” and now is being asked for payment by the nursing home? This guide recommends that the family member or friend consult with a knowledgeable attorney about how the nursing home’s demand can be countered. As discussed above, “Responsible Party” provisions are generally held to be illegal and unenforceable, if the court is made aware of the Reform Law’s relevant provisions.

#10 Forcing Residents to Give Up Legal Rights and Commit to Arbitration

What You Hear: ✘ *“Please sign this arbitration agreement. It’s no big deal. Arbitration allows disputes to be resolved quickly.”*

The Facts: ✔ **There is no good reason for a resident (or resident’s representative) to sign an arbitration agreement at the time of admission.**

In an arbitration agreement, the parties agree that future disputes between the parties will not go to court, but instead will be handled by a private judge called an arbitrator. Sometimes arbitration agreements apply to all disputes between the resident and the nursing home; other times, arbitration applies to claims made by the resident but not to claims made by the nursing home.

The arbitration process generally is not a good option for residents. The arbitration

process often is more expensive than a state or federal lawsuit, because the parties to the lawsuit are responsible for paying the arbitrator by the hour. Also, arbitrators often are less sympathetic to residents’ concerns than are judges or juries, and nursing homes commonly write arbitration agreements in a way that favors the nursing home over the resident.

In any case, there is no need for a resident to agree to arbitration at the time

of admission, when neither the resident nor the nursing home has any idea as to whether a dispute will arise, or what such a dispute might involve. If for whatever reason arbitration might be the best option for a resident, the decision (for or against arbitration) should be made after the dispute has arisen and the resident has consulted with a knowledgeable attorney.

What to Do to Challenge Arbitration Agreements

During Admission: If at all possible, a resident or resident's representative should not sign an arbitration agreement. In most cases, the nursing home will process the admission even without a signed arbitration agreement. If a nursing home employee raises a question, the resident or representative can explain that there is no need to commit to arbitration at the time of admission.

As in the "Responsible Party" situation discussed in Problem #9, a refusal to sign is not risky at all when a resident already has been admitted. Refusal to sign an arbitration agreement is not one of the six reasons for eviction under the Reform Law. (See Problem #19)

If the resident has not been admitted already, the resident or representative still has some leverage. In some states, a nursing

home can request but not demand the signing of an arbitration agreement. Also, regardless of state law, many arbitration agreements themselves include language that says that agreeing to arbitration is not required for admission.

In situations in which the resident has not moved into the nursing home yet, this guide recommends that the resident or resident's representative consider refusing to sign an arbitration agreement. As is the case with "Responsible Party" provisions, a polite but firm explanation is advisable. The nursing home staff likely will be too embarrassed or confused to object, and the benefit of standing firm is generally worth the risk of being denied a nursing home bed.

Of course, each situation is different, and residents and their representatives can tolerate different levels of risk. Consultation with a knowledgeable attorney may well be appropriate in many instances.

During or After Resident's Stay at Nursing Home, If Arbitration Agreement Previously Was Signed: A signed arbitration agreement may or may not be binding, depending on state law, the language of the arbitration agreement, and the circumstances surrounding the arbitration agreement's signing. A resident or resident's representative should consult with a knowledgeable attorney.

#11 Refusal to Bill Medicare

What You Hear: ✘ *“We have determined that you aren’t entitled to Medicare payment for your nursing home care, because of your limited health care needs.”*

The Facts: ☑ A resident can insist that the nursing home bill Medicare – the nursing home does not have the last word on whether the resident’s condition qualifies for Medicare payment. Once the nursing home is required to submit the bill, the nursing home has an incentive to consider with favor the resident’s need for therapy or any other qualifying skilled service.

Medicare is not a comprehensive health insurance program. One common limitation is that Medicare payment is often dependent upon a tie to hospital care. In the case of nursing home care, Medicare payment is limited to situations in which the resident has entered the nursing home within 30 days after a hospital stay of at least three nights.

At most, the Medicare program will pay in full for only 20 days of nursing home care. For the next 80 days – days 21 through 100 of the nursing home stay – the resident is required to pay a daily co-payment of \$157.50 (for 2015). This co-payment is covered by most Medicare Supplement insurance policies, which are often called “Medigap” policies.

(These benefits renew themselves in each benefit period. A new benefit period starts

when a resident for at least 60 days has not used Medicare payment either for hospital care or nursing home care.)

There is one additional limitation, and this is the limitation that keeps most residents from qualifying for Medicare payment for nursing home care. If a resident needs only “custodial care” – for example, medication administration – the Medicare program will not pay. Payment under Medicare is possible only if the resident needs skilled nursing services or skilled rehabilitation services. These skilled services generally must be provided every day, although an exception can allow for Medicare payment even if rehabilitation services are provided only five days per week.

“Skilled” services require the active and direct participation of a nurse or licensed therapist. It is not enough that a nurse is

overseeing the resident's care.

If a resident is a Medicare beneficiary, a nursing home is required to give the resident written notice whenever the nursing home first decides that it will not bill the Medicare program for the resident's care. Thus, this notice may be given when the resident first is admitted or may be given later, after the Medicare program has paid for nursing home care for a certain period of time.

The important fact is that the resident is not bound by a nursing home's decision that it will not bill the Medicare program. The resident can insist that the nursing home submit a bill to the Medicare program. If the nursing home properly has given written notice, the resident can return the notice to the nursing home after checking a box that requests that the nursing home submit a bill to the Medicare program for the resident's care. If the nursing home has failed to give the required notice, the resident can submit his own written request that the nursing home submit a bill.

While the Medicare program is considering a submitted bill, the nursing home may not charge the resident for any amount that the Medicare program subsequently may pay. If the Medicare program refuses to pay, the resident can make an appeal, although the resident will be financially liable for the bill while the appeal is pending. If the resident also were eligible for Medicaid, of course, the nursing home would be prohibited from charging anything more than the Medicaid monthly patient pay amount (see *A Brief Introduction to Medicare and Medicaid*, page 8).

What to Do to Obtain Medicare Eligibility

These issues most commonly arise in

relation to therapy. Assume that a resident is recovering from a broken hip. He will want therapy in order to regain the ability to walk. In such cases, timely receipt of therapy is crucial. If therapy is not provided, or is not provided for an adequate period of time, the resident may never walk again.

Counterbalancing the resident's need for therapy is the Medicare program's frequent reluctance to pay. Nursing homes receive pressure from the Medicare program to not submit bills, or to cease billing for residents whose nursing home care previously has been covered by the Medicare program. Nursing homes often pass this pressure on to doctors and therapists, encouraging them to discontinue therapy services.

In combatting this pressure, the resident must do battle on two fronts – the resident both must compel the nursing home to submit a bill to the Medicare program, and convince the doctor (or therapist) to continue ordering (or recommending) therapy services. Battle on the first front is relatively easy – as explained in this guide, the resident can require the nursing home to submit a bill to the Medicare program.

But, of course, submitting a bill will prove futile unless the resident actually receives the therapy services that would qualify him for Medicare payment for nursing home care. The resident (or resident's representative) should encourage the doctor or therapist to initiate or continue appropriate therapy services. In many instances, the doctor or therapist may be just as frustrated as the resident by the pressure that discourages necessary therapy. The resident or resident's representative should encourage the doctor or therapist to focus on medical considerations and leave the Medicare-related issues to the resident or resident's representative. In certain cases, the resident may want to switch to a different

doctor, if the second doctor is more aware of the resident's need for therapy.

If a doctor orders therapy, the nursing home must provide it. A nursing home always must follow doctors' orders (assuming that the resident or resident's representative consents).

The two advocacy steps – relating to the nursing home, and to the doctor and/

or therapist – reinforce each other. If the nursing home is forced to submit a bill, the nursing home has an incentive to make sure that the resident receives services that justify Medicare payment. Similarly, if the doctor or therapist is persuaded to provide therapy services, then the doctor and the therapist have a financial interest in ensuring that the Medicare program will pay for those services.

#12 Losing Therapy for Supposed Failure to Make Progress

What You Hear: ✘ *“We must discontinue therapy services because you aren't making progress.”*

The Facts: ✔ **Therapy may be appropriate even if a resident is not making measurable progress. Accordingly, the Medicare program can pay for therapy services even if progress for the time being is not being made.**

A nursing home sometimes moves to stop therapy prematurely. The nursing home commonly claims that the resident has “plateaued” – in other words, that he is no longer making progress.

Most likely, the real reason for the termination is part medical and part financial. Possibly, the resident's progress has slowed or temporarily stopped. Then, because the nursing home has been pressured by the Medicare program, the nursing home is too quick to terminate therapy, even when the resident still can benefit.

A resident or resident's representative should keep in mind that recovery from an illness or injury is not always steady. If, for example, a resident is recovering from a broken hip, it is understandable that he

would have good days and bad days. If he were to walk 15 feet unassisted on Tuesday, therapy likely still would be advisable if on Wednesday he were still only able to walk 15 feet, or even just 10 feet.

Under the Nursing Home Reform Law, as discussed in this guide's *Introduction*, a nursing home resident must be provided with medically necessary care. Thus, therapy should be provided if the therapy improves the resident's condition, maintains the resident's condition, or slows the decline of the resident's condition. (See Section 483.25(a) of Title 42 of the Code of Federal Regulations; CMS, *Jimmo v. Sebelius* Settlement Agreement Fact Sheet)

If the termination of therapy is blamed on Medicare rules, there are two rebuttal

points to be made. First, as explained in this guide's discussion of Problem #1, a nursing home must provide the same high quality of care whether the resident's care is funded through private funds, Medicare or Medicaid.

Second, the Medicare program can pay for therapy services even if, for the time being, no progress is being made. A relevant federal regulation states:

The restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities. (Section 409.32(c) of Title 42 of the Code of Federal Regulations)

What to Do When Told That the Resident Has 'Plateaued'

The resident or resident's representative should follow the same general strategy recommended for Problem #11. Again, there are two basic advocacy steps: forcing the nursing home to submit a bill to the Medicare program, and convincing the doctor or therapist that therapy is the right thing to do.

The important point is that a lack of progress is not an automatic reason for terminating therapy. If therapy is completely futile then, yes, therapy should not be provided. But if therapy can improve or maintain a resident's condition, then it should be provided. This is good medicine, and consistent with relevant Medicare rules.

#13 Losing Therapy After Medicare Payment Has Ended

What You Hear: ✘ *"We can't give you therapy services because your Medicare payment has expired, and Medicaid doesn't pay for therapy."*

The Facts: ✔ **Therapy should be provided whenever medically appropriate, regardless of the resident's source of payment.**

Therapy should not be discontinued just because a resident has reached the end of his 100 days of Medicare coverage. The two reasons have been discussed already in this guide. A resident is entitled to receive medically necessary services. Also, a resident's services shouldn't depend on his source of payment. Specifically, a Medicaid-eligible

resident is entitled to the same level of service provided to other residents. (See *Introduction and Problem #1 for discussion of these two issues.*)

Accordingly, federal guidelines explicitly require that therapy services be provided even if the nursing home is entitled to no more than the typical Medicaid rate. (See

Guideline to Section 483.45(a) of Title 42 of the Code of Federal Regulations, Appendix PP to State Operations Manual of Centers for Medicare and Medicaid Services)

In some states, in addition, a nursing home may be entitled to extra Medicaid payment for therapy services provided to residents.

What to Do to Continue Therapy

The resident or resident's representative should explain the relevant rules to the

nursing home, the doctor, and the therapist. The most important person to convince is the doctor, since the nursing home and the therapist are required to comply with a doctor's orders. The focus should be placed on the resident's need for therapy, rather than on the nursing home's finances. In limited cases, the resident may benefit by switching from one doctor to another, if the second doctor is more conscious of the resident's continued need for therapy.

#14 Forced Transfer within Nursing Home After Medicare Payment Ends

What You Hear: ✘ *“Because you are no longer eligible for Medicare payment, you must leave this Medicare-certified bed.”*

The Facts: ✔ **A Medicare-certified bed can be occupied by a resident whose care is not being reimbursed through the Medicare program.**

Understanding this issue requires an explanation of how nursing home beds are certified by the Medicare program. A nursing home may seek Medicare certification for all or some of its beds. A bed must be Medicare-certified for the nursing home to bill Medicare for care provided to the resident assigned to that bed.

Medicare certification does *not* mean that the bed is reserved exclusively for residents whose care is being paid for by the Medicare program. A Medicare-certified bed can be occupied by a resident who is paying privately, or through private insurance. A Medicare-certified bed in addition can be occupied by a resident who is paying

through the Medicaid program, assuming that the bed also is certified for Medicaid payment.

Because the Medicare program generally pays more per day than any other source of payment, nursing homes prefer to use Medicare-certified beds for residents whose care is being reimbursed through Medicare. Once a resident is no longer eligible for Medicare payment of his nursing home expenses (see this guide's discussion of Problems #11 and #12 for more details), the nursing home has an incentive to move that resident out of the Medicare-certified bed, so that the nursing home can use the bed for a resident who is eligible for Medicare payment.

Although shuttling residents around in this fashion may make financial sense for a nursing home, it can be detrimental to a resident. The resident may have grown accustomed to his original room. Also, because Medicare payment is available only to those residents who need skilled nursing or rehabilitation services, the nursing care provided in the Medicare-certified beds may be generally better than the nursing care provided in the rest of the nursing home.

To protect residents, the Nursing Home Reform Law gives a resident the right to veto a transfer within the nursing home if the purpose of the transfer is to move the resident out of a Medicare-certified bed. (See Section 483.10(o) of Title 42 of the Code of Federal Regulations) This right provides a counterbalance to the Medicare program's transfer-encouraging financial incentives.

What to Do to Stay in a Medicare-Certified Bed

If a resident does not want to leave a Medicare-certified bed, he should not hesitate to assert his veto right.

If the resident will be relying on Medicaid payment, he should be sure that the bed is Medicaid-certified. In some states, Medicaid

certification is an all-or-nothing proposition: if the nursing home has Medicaid certification, every single bed is Medicaid-certified. Other states allow nursing homes to certify only a portion of their beds for Medicaid. More information on this topic is provided in the discussion of Problem #15.

General information about a nursing home's certification is available at the federal government's Nursing Home Compare website, www.medicare.gov/nursing-homecompare/search.html. More detailed information about the certification of particular beds should be available at the state agency that inspects, certifies and licenses nursing homes (often part of the state's Health Department). The nursing home may or may not be able to provide accurate information on the Medicaid certification of particular beds.

When a resident refuses a transfer from a Medicare-certified bed, the nursing home often complains that such transfers ultimately will cause all of the nursing home's Medicare-certified beds to be occupied by the residents who are ineligible for Medicare payment. In response, the resident should point out that the nursing home always is free to certify additional beds for Medicare payment. There is nothing preventing any nursing home from seeking Medicare certification for every single one of its beds.

#15 Refusal to Accept Medicaid

What You Hear: ✘ *“Even though you’re now financially eligible for Medicaid payment, we don’t have an available Medicaid bed for you.”*

The Facts: ✔ A nursing home can certify additional beds for Medicaid payment.

As mentioned in the discussion of the previous problem, some states allow a nursing home to certify only a percentage of its beds for Medicaid payment. Such partial certification creates a particular problem when a resident initially pays privately for her nursing home care, but later becomes eligible for Medicaid payment after spending her savings down to Medicaid limits.

If at that time the resident is not in a Medicaid-certified bed, and the nursing home does not have an available Medicaid-certified bed, the nursing home likely will state that it cannot accept Medicaid payment on the resident’s behalf. This may lead to nonpayment and then eviction, because the resident will have spent down her savings and will be unable to pay the private-pay rate.

It is important that a resident or resident’s representative understands that the nursing home in this situation has the option of certifying additional beds for Medicaid payment.

Nursing home employees often give the impression that partial Medicaid certification is forced upon the nursing home, but that is not true. Even in the states that allow partial certification, a nursing home is free to seek certification for every bed.

What to Do to Obtain a Medicaid-Certified Bed

Resolution of this problem requires early action.

Ideally, information regarding a nursing home’s Medicaid certification should be obtained prior to admission, as part of the process of choosing the nursing home. As soon as possible, the resident (or resident’s representative) should determine whether the nursing home accepts Medicaid payment and, if the nursing home accepts Medicaid, whether the Medicaid certification is full or partial. The resident after admission should determine whether her current bed is Medicaid-certified.

As mentioned in the discussion of the preceding problem, general information about a nursing home’s certification is available on the federal government’s Nursing Home Compare website. Information about the certification of a particular bed should be available from the state’s inspection agency. Information also can be obtained from the nursing home; if a dispute arises, however, it is best to examine the government records to cross-check information provided by the nursing home.

If a resident foresees herself in the

situation discussed earlier in this problem – being financially eligible for Medicaid, but in a bed not certified for Medicaid – she as soon as possible should request that the nursing home seek certification for her bed from the appropriate state agency. Ideally, this request should be made from four to six months before the resident becomes financially eligible for Medicaid.

In making this request, the resident puts the nursing home on notice that she will need to use Medicaid payment. In most cases, in order to avoid disputes, the

nursing home will take the necessary steps for the resident to have a Medicaid-certified bed. If the nursing home fails to obtain a Medicaid-certified bed for the resident, and instead tries to evict the resident for nonpayment when the resident becomes Medicaid-eligible financially, the resident in an eviction hearing will have a good argument that the nonpayment is the nursing home's fault.

Eviction procedures and appeals are discussed in Problem #19.

#16 Refusal to Readmit from Hospital

What You Hear: ✘ *“We don’t want to readmit you from the hospital because your bed-hold period has expired.”*

The Facts: ✔ **A Medicaid-eligible resident has the right to be admitted to the next available Medicaid-certified bed, regardless of the length of hospital stay.**

When a nursing home resident is hospitalized, the nursing home generally is required by state law to hold the bed for a week or two, if the resident wants the bed to be held. If the resident is paying privately, she will be responsible for paying for the bed hold. If the resident is Medicaid-eligible, the Medicaid program generally will pay for the bed hold.

In addition, the Nursing Home Reform Law establishes a readmission right for Medicaid-eligible residents. Even if a bed hold period is exceeded (or if state law does not require a bed hold), a nursing home must admit a Medicaid-eligible resident to

the next available Medicaid-certified bed, no matter how long the hospitalization has lasted. (See Section 483.12(b) of Title 42 of the Code of Federal Regulations) A bed is not considered available if the hospitalized resident and the proposed roommate are not of the same gender.

This provision of the Reform Law is a reasonable compromise to protect a resident from being moved unnecessarily to a new nursing home. Because the Medicaid program generally pays a relatively low rate, Medicaid-eligible residents are often seen as less desirable by finance-conscious nursing homes. For this reason, Medicaid-eligible

residents can benefit from special protections.

Nonetheless, it doesn't make sense for the Medicaid program to pay to hold a vacant bed for a long period of time. It does make sense, however, for a nursing home to be required to readmit a Medicaid-eligible resident to the next available Medicaid-certified bed. Since the nursing home has a vacancy anyway, the resident's right to be readmitted should not inconvenience the nursing home in any significant way.

What to Do to Be Readmitted from the Hospital

A Medicaid-eligible resident should not hesitate to assert her right to be readmitted to the next available Medicaid-certified bed. The resident should be persistent if the nursing home claims that it does not have a vacancy. If the nursing home is led to believe that the resident will keep checking and checking for the next available bed, the nursing home will be more likely to accept the inevitable and readmit the resident.

If the nursing home indicates that it has no intention of readmitting the resident, she should make a complaint to the state inspection agency and/or consult with a knowledgeable attorney.

#17 Excessive Charges

What You Hear: ✘ *"You must pay any amount set by the nursing home for extra charges."*

The Facts: ✔ **A nursing home can assess extra charges only if those charges were authorized in the admission agreement.**

Some nursing homes charge separately for various items and services – for example, catheter supplies, diapers and other incontinence products, and wound dressings. These separate charges are inappropriate if the resident's care is covered by Medicare or Medicaid, because the nursing home must accept payment from Medicare or Medicaid as payment in full. The resident's only financial obligation is to pay the deductibles and co-payments authorized by law.

Such separate charges also are inap-

propriate if they were not authorized in the admission agreement, whether or not the resident's care is covered by Medicare or Medicaid. Federal regulations to the Nursing Home Reform Law require that a nursing home during the admissions process notify residents of any extra charges. (See Section 483.10(b)(6) of Title 42 of the Code of Federal Regulations) Also, standard principles of contract law require a nursing home to limit its charges to the amount authorized by the admission agreement.

What to Do to Challenge Extra Charges

Assume that a resident is not eligible for Medicare or Medicaid payment, and his admission agreement lists a monthly rate of \$5,000, with no mention of additional charges. This month, however, he has been charged a total of \$5,211.50 – the \$5,000 monthly rate plus \$211.50 for various items and services.

The resident has at least two choices and, as is often true, the riskier choice has the largest potential upside. The riskier choice is to refuse to pay the unauthorized extra charges, with a written explanation to the nursing home that the admission agreement obligates the resident to pay only \$5,000 monthly. The nursing home likely will accept the \$5,000 grudgingly and will take no action against the resident. If, however, the nursing home tries to evict the resident for nonpayment, the resident can claim with justification that he has paid in full under the terms of the admission agreement. The

resident likely will prevail in an eviction hearing although, of course, there can be no guarantees in any legal proceeding. (See Problem #19 for discussion of evictions and eviction procedures.)

The less risky course of action is to make a complaint to the state agency that inspects and licenses nursing homes. Ideally, the state agency will order the nursing home to stop assessing extra charges against the resident. One downside of this approach is that these agencies are often hesitant to rule on financial matters. Their expertise is in health care, and a complaint regarding billing likely will receive the lowest priority.

The advantage of the pay-only-what-is-owed strategy is that it gives the resident some power over the situation. If the resident pays only \$5,000, then the nursing home has the burden to change the status quo. On the other hand, if the resident pays the \$5,000 plus the extra charges, then the burden remains on the resident to somehow change the nursing home's practices.

#18 Refusal to Support Resident and Family Councils

What You Hear: ✘ *“We have no available space in which residents or family members could meet.”*

The Facts: ✔ **A nursing home must provide meeting space for a resident or family council.**

Under the Nursing Home Reform Law, residents and residents' family members have the right to form resident councils and family councils, respectively. If such a group forms, a nursing home is obligated to provide the group with a private meeting space, and must designate an employee as

a liaison with the group. A nursing home must seriously consider, and respond to, all complaints or recommendations made by a resident or family council. (See Section 483.15(c) of Title 42 of the Code of Federal Regulations)

What to Do to Organize Resident and Family Councils

It's a cliché but it's true – there is strength in numbers. Resident and family councils can be a powerful mechanism for making positive changes in a nursing home. A resident or family council is a good forum in which to raise any of the issues discussed

in this guide, or any other issue related to the nursing home.

Residents and family members should do their best to make sure that a council does not become merely a show-and-tell session for the nursing home. Nursing home employees can be guests at a council meeting, but they should not run or control a meeting.

Problems #19–20: Eviction

#19 Eviction Threatened For Being 'Difficult'

What You Hear: ✘ *“You must leave the nursing home because you are a difficult resident.”*

The Facts: ✔ **Eviction is allowed for only six limited reasons.**

Under the Nursing Home Reform Law, there are only six legitimate reasons for eviction:

1. The resident has failed to pay.
2. The resident no longer needs nursing home care.
3. The resident's needs cannot be met in a nursing home.
4. The resident's presence in the nursing home endangers others' safety.
5. The resident's presence in the nursing home endangers others' health.
6. The nursing home is going out of business.

(See Section 483.12(a) of Title 42 of the Code of Federal Regulations)

Thus, being “difficult” is not a justification for eviction. The important thing to remember is that nursing homes exist in order to care for people with physical and cognitive problems. Most nursing home residents are “difficult” in one way or another.

Some nursing homes attempt to evict a resident because (for example) the resident tends to wander aimlessly, or has severe dementia and is making loud sounds during the night. These evictions almost always are improper, because such residents belong in a nursing home. The fact that they are arguably “difficult” does not mean that they should be evicted. In most cases, it is pointless to evict a resident from one nursing home merely so he can be transferred to

another nursing home.

A nursing home may cite reason #3, arguing that it cannot meet the needs of the supposedly “difficult” resident. This argument is wrong, because reason #3 only applies if the resident’s needs cannot be met in a nursing home generally – for example, if the resident needs placement in a subacute unit or a locked psychiatric ward. The federal government has stated that a nursing home cannot use its own inadequate care as a justification for eviction under reason #3 (See Federal Register, vol. 56, page 48,839 [Sept. 26, 1991]).

What to Do to Challenge Eviction for Being ‘Difficult’

To evict a resident, a nursing home must give a written notice that lists the reason for the eviction, along with the facts that allegedly support the eviction. The notice must list the telephone number for the state agency that inspects and licenses nursing homes, along with instructions on how the resident can request an appeal from the agency. Generally the notice must be given at least 30 days prior to the date of the proposed eviction.

Upon receiving the notice, the resident or resident’s representative should request an appeal from the state agency. In response, the state will schedule an appeal hearing.

The hearing generally will be held at the nursing home by a state hearing officer. It is preferable but not essential that the resident be represented by a lawyer, ombudsman program representative, or other advocate. The hearings tend to be relatively informal.

At a hearing, the resident and his family should emphasize that the resident is appropriate for a nursing home. In most cases, it can be shown that the nursing home did not do adequate care planning, and instead tried to evict the resident when a difficulty presented itself.

Oftentimes the nursing home proposes to transfer the resident to another nursing home. This is good evidence that the resident is appropriate for nursing home care. After all, if the second nursing home can provide adequate and appropriate care, there probably is no reason why a similar level could not be provided by the resident’s current nursing home.

The resident should resist the inclination to give up. Sometimes a resident will think, “If the nursing home doesn’t want me, then I’m better off going elsewhere.” The reality is, however, that the second nursing home may be no better – or may be worse – than the first one. A resident who fights an eviction, wins and stays may find himself receiving more respect and better care from the nursing home.

#20 Eviction Threatened For Refusing Medical Treatment

What You Hear: ✘ *“You must leave the nursing home because you are refusing medical treatment.”*

The Facts: ✔ Refusal of treatment, by itself, is not an allowable reason for eviction.

A nursing home resident, like any other individual, has a constitutional and common-law right to refuse medical treatment. For that reason, an eviction cannot be based solely on a resident’s refusal of treatment.

As discussed above, eviction is only allowed for one of the six specified reasons. Federal nursing home guidelines state: “Refusal of treatment would not constitute grounds for transfer, unless the [nursing home] is unable to meet the needs of the resident or protect the health and safety of others.” (Surveyor’s Guideline to Section 483.12(a)(2) of Title 42 of the Code of Federal Regulations, Appendix PP to CMS State Operations Manual)

On occasion, a resident refuses treatment because he is terminally ill and does not want to take steps to extend his life. This is his right, and he should not be forced to move from the nursing home for this reason.

A small number of nursing homes, mostly affiliated with religious denominations, have policies that require provision of life-sustaining treatment under all circumstances. A nursing home can follow such a policy only if allowed by state law, and only if the policy is described in considerable detail during a resident’s admission.

What to Do to Challenge Eviction for Refusing Medical Treatment

Following the procedures discussed above in Problem #19, a resident or resident’s representative should appeal an eviction based on refusal of treatment. At the hearing, the resident or representative should be prepared to discuss how the refusal of treatment does not endanger others, and why the resident does not need a higher level of care (such as a hospital or subacute unit).

Concluding Thoughts

These 20 problems are unfortunately common. But it doesn't have to be that way. These problems are reduced significantly when residents and family members are more knowledgeable about the Nursing Home Reform Law's protections, and more willing to be the squeaky wheels that get the grease.

This guide's advice to residents and family members is: "Speak up." You may feel embarrassed or awkward at first, but don't let that stop you. It is the nursing home that should be embarrassed when it is violating the Reform Law.

Nursing home residents deserve high-quality nursing home care. For this high-quality care to become reality, residents and family members must speak up and be heard.

About Justice in Aging

Justice in Aging is a national non-profit legal advocacy organization that fights senior poverty through law. Formerly the National Senior Citizens Law Center, since 1972 we've worked for access to affordable health care and economic security for older adults with limited resources, focusing especially on populations that have traditionally lacked legal protection such as women, people of color, LGBT individuals, and people with limited English proficiency. Through targeted advocacy, litigation, and the trainings and resources we provide to local advocates, we ensure access to the social safety net programs that poor seniors depend on, including Medicare, Medicaid, Social Security, and Supplemental Security Income (SSI). And we work to build a health care system that honors choice and includes strong consumer protections for all seniors.

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