

25 Common Nursing Home Problems— & How to Resolve Them



Introduction

USING THIS GUIDE

Beware: these 25 problems occur across the country. They happen in cities, suburbs, and rural communities. They also happen both in “good” and “bad” nursing homes. Even the better nursing homes tend to follow standard procedures that violate federal law and harm residents.

The best way to receive high quality care is to settle for nothing else, each and every day. This guide gives you the tools to do exactly that.

This guide is an updated and expanded version of *20 Common Nursing Home Problems – and How to Resolve Them*, which was written with financial support from the Commonwealth Fund. This revision, like the original edition, introduces each common problem by identifying a false statement commonly made by nursing home staff, along with a clear statement of the relevant law.

This new edition addresses additional problems, discusses issues in more detail, and includes recent revisions to federal regulations and guidance. This edition emphasizes strategies to prevent evictions, as described in the discussion of Problems #7 through #14.

Whether you are a nursing home resident, a family member, or a supportive friend, this guide gives you the tools you need to identify and then resolve the problems that residents most frequently face. Your determined advocacy can be the difference between going-through-the-motions nursing home care, and the high quality, person-centered care that residents are promised by federal law.

THE NURSING HOME REFORM LAW

Federal nursing home law applies across the country, and is called the Nursing Home Reform Law.¹ The Reform Law 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 utilizing Medicare or Medicaid payment. Because Medicare and Medicaid are important sources of payment, almost all nursing homes are governed by the Reform Law. Information on Medicare or Medicaid certification for a particular nursing home is available on the federal government’s [Care Compare website](#).²

The Reform Law’s cornerstone is the requirement that each nursing home provide the care needed by a resident to reach the highest practicable level of functioning.³ 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 each of these situations, the nursing home must provide all necessary and appropriate care.

The Reform Law’s regulations are found in Title 42 of the Code of Federal Regulations, from sections 483.1 through 483.95. Guidance to government surveyors on how to interpret and apply these regulations is compiled in Surveyor’s Guidelines at Appendix PP to the State Operations Manual of the Centers for Medicare & Medicaid Services (CMS). To find this manual, search the

Internet for “CMS Manuals” and choose “Internet-Only Manuals” as your starting place. The State Operations Manual is listed as CMS Publication #100-07.

WHERE TO GO FOR HELP

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 help can be the long-term care ombudsman program. Each state has an ombudsman program that provides advocacy for nursing home residents without 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.⁴

Each state maintains an inspection agency (often part of the state’s Health Department) that monitors nursing homes’ compliance with the Reform Law, certifies nursing homes for participation in Medicare and Medicaid, and issues state licenses. Each of these agencies will investigate 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 website](#) has many helpful publications for nursing home residents and their families. The federal government’s [Care Compare website](#) provides extensive information on individual nursing homes.

IMPORTANT NOTE

This guide cannot substitute for the individualized assistance of an attorney or other relevant professional. If you require legal or other expert advice, please speak with a competent professional in your area.

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Recommendation: Speak Up!

Can it really be possible that many nursing homes follow unlawful procedures? Regrettably, the answer is an emphatic “yes,” based on the author’s experiences over more than 25 years.

The next question is “How?” How can it be that so many nursing homes routinely violate the Nursing Home Reform Law?

Certainly part of the answer is consumers’ unfamiliarity with nursing homes and the Reform Law’s protections. Another part is the unwillingness of residents and family members to complain, due to shyness and a fear that a nursing home will retaliate. Together, this lack of knowledge, shyness, and fear of retaliation allow some nursing homes to develop and follow unlawful procedures.

This timidity can harm residents. Residents and families must understand and believe that the resident *deserves* high-quality nursing home care. A nursing home receives thousands of dollars monthly to care for a resident, and is required by the Reform Law to provide individualized care. Residents shouldn’t feel sheepish to ask (for example) for necessary physical therapy, or to be allowed to sleep as long as they want.

Federal law prohibits a nursing home from retaliating against someone for making a complaint.⁵ In any case, risk of retaliation is relatively small 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 administrators and nurses, but it is the nurse aides that provide most of the day-to-day care. In any case, the issues covered in this guide are, in most instances, focused on nursing home policy and 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 be overlooked. On the other hand, if a resident and family are determined (but generally polite) in asking for individualized care, the resident likely will receive more attention and better care.

A Brief Introduction to Medicare, Medicaid & Medicare Advantage

ELIGIBILITY

Under both the Medicare and Medicaid programs, an adult beneficiary generally must be at least 65 years old, or disabled, to be eligible. But the programs’ financial requirements differ greatly. Medicare eligibility is based on payroll deductions during the lifetime of the beneficiary or beneficiary’s spouse. Think of Medicare coverage as a health insurance policy purchased through premiums deducted from payroll checks.

By contrast, financial eligibility under Medicaid is based not on payroll deductions but instead on need: a beneficiary must have limited resources and income. Think of the Medicaid program as a safety-net health care program for persons who otherwise cannot afford health care. Medicaid rules vary somewhat from state to state, since the program uses both federal and state funding.

The Medicare Advantage program is an alternate way for a Medicare beneficiary to receive Medicare benefits. Under Medicare Advantage, a managed care plan authorizes and coordinates the beneficiary's Medicare benefits. In general, all of the beneficiary's Medicare-funded services must be provided by health care providers from the plan's network.

Medicare Advantage is voluntary—the beneficiary chooses whether to convert the traditional Medicare coverage to the Medicare Advantage managed care model. The Medicare Advantage plan must offer at least the same level of benefits offered by Medicare, and generally promises additional benefits and/or reduced cost sharing as an incentive to join.

Why do beneficiaries choose to convert Medicare coverage to Medicare Advantage? The principal reasons are the increased benefits and reduced cost sharing mentioned above, along with the potential of better care coordination. On the other hand, a Medicare Advantage member generally can receive services only from providers in the plan's network. Also, because a Medicare Advantage plan receives a fixed monthly per-member payment from Medicare, the plan may have a financial incentive to reduce expenses by denying requested services.

PAYMENT FOR NURSING HOME CARE

The Medicare and Medicaid programs differ in how they pay for nursing home care. Because the Medicaid program is (as described above) a safety-net program for persons who otherwise cannot afford health care, Medicaid can 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 uses the term "patient pay amount."

The Medicare program, by contrast, pays for nursing home care for only a limited period of time. At most, Medicare can pay for only 100 days of nursing home care per benefit period. A new benefit period starts when the Medicare beneficiary has not received Medicare-covered inpatient care in a nursing home or hospital for at least 60 days. (Note: During the ongoing COVID-19 emergency period, a new benefit period can start immediately after the preceding benefit period, if the emergency is preventing the benefit period from being restarted.)

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 \$194.50 (for 2022). 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 enters 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. (Note: The three-night requirement

is waived during the ongoing COVID-19 emergency period, in order to reduce any incentive that a person stay in a hospital longer than necessary.)

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 detail in this guide’s discussions of Problems #16 through #20. Because of this skilled care requirement, the average Medicare-funded stay in a nursing home lasts less than 30 days.

Medicare Advantage coverage generally is similar but not identical to coverage provided by traditional Medicare. To incentivize enrollment, the plan likely will offer more than 100 days of coverage per benefit period, and reduce or eliminate co-payments. Other requirements, however, are more likely to be identical to the standards followed in traditional Medicare—for example, a required three-night hospital stay, or a resident’s need for skilled nursing services or skilled rehabilitation services.

COMPARING COVERAGE	
<p>MEDICAID</p> <ul style="list-style-type: none"> ○ Pays as long as resident needs nursing home care and remains financially eligible. ○ Resident’s financial obligation, if any, based on income. 	<p>MEDICARE</p> <ul style="list-style-type: none"> ○ Must follow acute-care hospitalization of at least three nights (waived during current COVID-19 emergency period). ○ Resident must need skilled rehabilitation services or skilled nursing services. ○ No more than 100 days, with no more than 20 days paid in full. ○ Daily co-payment of \$194.50 for day 21 and beyond (in 2022; generally increases each year).

A Brief Introduction to the Nursing Home Grievance Process

Each nursing home must have a Grievance Official to accept, investigate, and respond to grievances. Grievances can be made orally or in writing, but the nursing home's response must be in writing.

The nursing home's written response must include all of the following:

1. **The date the grievance was received;**
2. **A summary of the grievance;**
3. **Steps taken to investigate the grievance;**
4. **A summary of the nursing home's conclusions following the investigation;**
5. **A statement as to whether the grievance was confirmed or not;**
6. **Any corrective action taken by the nursing home; and**
7. **The date of the written response.**

Each nursing home is required to post information on the nursing home's grievance procedures, along with contact information for the Grievance Official. Upon request, a nursing home must provide a resident or resident representative with a copy of the nursing home's grievance policy.

Problem #1: Providing Less Care to Medicaid-Eligible Residents

WHAT YOU HEAR:

“MEDICAID DOES NOT PAY FOR ONE-ON-ONE ATTENTION.”

THE FACTS:

A MEDICAID-ELIGIBLE RESIDENT IS ENTITLED TO THE SAME LEVEL OF SERVICE PROVIDED TO ANY OTHER RESIDENT.

Nursing homes often claim that certain types of care are not covered under Medicaid. Staff may claim (for example) that a Medicaid-eligible resident cannot receive physical therapy, one-on-one attention, or hands-on assistance with eating.

All such claims are wrong: the Nursing Home Reform Law prohibits a nursing home from restricting services based on Medicaid eligibility. A nursing home “must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State [Medicaid] plan for all residents *regardless of payment source.*”⁶

HOW TO PROTECT MEDICAID-ELIGIBLE RESIDENTS

A Medicaid-eligible resident should resist any attempt by the nursing home to give second-class treatment. 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. Residents should push back hard against any arguments based on a nursing home’s supposedly limited finances. What would you think if a doctor, lawyer, or contractor blamed poor performance on a supposedly inadequate rate of pay? You would reject such excuses, and demand that the work be done well. The same should be true when dealing with a nursing home.

Or consider promises made by nursing homes. When applying for Medicaid certification, a nursing home promises federal and state governments that it will provide Medicaid-eligible residents with the care guaranteed by the Nursing Home Reform Law. The nursing home can’t have it both ways: it is completely unfair for a nursing home to accept Medicaid money for a resident’s care, and then turn around and tell the resident that care will be substandard because the nursing home believes that Medicaid payment rates are too low.

If a nursing home feels that Medicaid rates truly are too low, it should withdraw from Medicaid. But as long as the nursing home continues to bill Medicaid, it must provide Medicaid-eligible residents with the high-quality care the Reform Law requires.

A resident or resident’s representative can raise these concerns with the nurses and nurse aides that assist the resident. In addition, the resident or representative can file a grievance with the nursing home’s Grievance Official (see page 9).

Problem #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 CAN PARTICIPATE IN DEVELOPING A CARE PLAN.

A nursing home must prepare a full written 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”). Full assessments include dozens of items related to the resident’s condition, including the ability to perform activities of daily living, preferences for daily routines, health care needs, and interest in moving out of the nursing home.

These assessments are used to develop 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, a nurse aide who works with the resident, 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.⁷ The care plan must be “person-centered” so that the resident can make choices and have control over their life. Under federal Surveyor’s Guidelines, the nursing home staff must take steps to facilitate family participation, including scheduling care planning meetings at workable times for family members, or setting up conference calls or video conferencing.

HOW TO ENSURE A GOOD CARE PLAN

The resident and 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.

Take care planning seriously. An individualized care plan can be invaluable in improving a resident’s life.

Prior to a care plan meeting, the resident or family member should think creatively about what the resident might want or appreciate. Don't be timid. A nursing home receives thousands of dollars monthly to care for a resident, and is required by the Reform Law to address a resident's specific needs and preferences (see "Disregarding Resident Preferences" for more information on resident preferences).

Some nursing homes treat care plans as a meaningless formality, resulting in care plans that are heavily repetitive from one resident to another. Such drowsy care planning can harm residents. To be meaningful, a care plan truly should address individual residents' 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?" This sense of intimidation or shyness is only intensified by the fact that, in a care plan meeting, a resident or family member is likely outnumbered by nursing home staff members.

Resist any sense of intimidation. Actually, most care planning decisions do not involve complicated medical issues. Instead, the optimal plan of care is relatively obvious; the main issue is whether 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 it be written into the care plan.

Once the care plan is in place, the resident or family member can use it as needed to ensure that the resident receives the best possible care. Assume for example that the care plan calls for the resident to walk around the block daily, with assistance, but the nursing home fails to make a staff member available to assist the resident. In addressing this problem, the resident or family member can point to the care plan as requiring the nursing home to provide the necessary assistance.

What Might a Care Plan Include?

Here are some examples:

- Assistance with daily activities such as dressing, eating, and using the toilet
- Assistance with brushing teeth or cleaning dentures
- A favorite game or song
- Dietary restrictions and preferences
- Need to be repositioned frequently in order to avoid skin breakdowns
- Exercises
- Interest in visiting a nearby park
- Preferred schedule for waking up and going to bed
- Preparations for moving out of the nursing home

Problem #3: Disregarding Resident Preferences

WHAT YOU HEAR:

“WE DON’T HAVE ENOUGH STAFF TO ACCOMMODATE INDIVIDUAL SCHEDULES. YOU MUST WAKE UP AT 6 A.M. EVERY MORNING.”

“OUR GROUP ACTIVITY ALWAYS IS BINGO.”

“IF YOU DON’T LIKE THE DINNER ENTRÉE, YOUR ONLY OPTION IS A PEANUT BUTTER SANDWICH.”

THE FACTS:

A NURSING HOME MUST MAKE REASONABLE ADJUSTMENTS TO HONOR A RESIDENT’S NEEDS AND PREFERENCES.

The ability to make choices is vital to a resident’s quality of life. A nursing home should feel like a home rather than a health care assembly line.

Consistent with these principles, a nursing home must make reasonable adjustments to meet resident needs and preferences. For example, a resident has the “right to choose activities, schedules (including sleeping and waking times), health care, and providers of health care services consistent with his or her interests, assessments, [and] plan of care.”⁸

The resident or resident’s representative should not feel bound by a nursing home’s standard operating procedures. It does not necessarily matter that 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 critical 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 is worth whatever inconvenience or expense may be involved.

More enlightened nursing homes are realizing the benefits—both to residents and the nursing homes—of giving more control to residents and individual staff members. The goal: to change nursing home culture so care is more person-centered. By changing the culture, 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.”

HOW TO PROMOTE RESIDENT CHOICE

Again, a resident or resident’s representative should not hesitate in making requests. The nursing home receives thousands of dollars for the care of each resident. And money aside, there are legal and moral reasons for treating each and every resident as an individual human being.

Letting a resident sleep past 6 a.m. (or 7 a.m. or 8 a.m.) is easily supportable: of course an adult would not want to be forced awake every single day. The nursing home could adjust its nurse aide schedules and, as necessary, increase nurse aide staffing levels. 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 (see “Failing to Take Care Planning Seriously”). Furthermore, the resident or representative may wish to file a grievance with the nursing home’s Grievance Official (see page 9).

A resident council or family council (see “Refusal to Support Resident and Family Councils”) can be a good place in which to organize support for a change in a nursing home’s procedures, and specifically for more person-centered care. Strength is in numbers: if an entire group of residents and family members pushes for a particular change, the nursing home is much more likely to see the light.

Problem #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.

As previously discussed, the Reform Law’s cornerstone is the requirement that each nursing home provide the care necessary for a resident to reach the highest practicable level of functioning.⁹ A nursing home violates that requirement by expecting or encouraging the hiring of private-duty aides to cover for the nursing home’s inadequacies.

WHAT TO DO TO ENSURE ALL NECESSARY SERVICES ARE PROVIDED

The resident or family member should make clear that the nursing home has the 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 to the nursing home's Grievance Official (see page 9); 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 deny 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 "Refusal to Support Resident and Family Councils"), seeking assistance from the long-term care ombudsman program (see "Introduction"), or consulting with an attorney.

Problem #5: Improper Use of Physical Restraints

WHAT YOU HEAR:

"YOUR FATHER MAY FALL IF WE DON'T TIE HIM INTO A CHAIR. THERE'S JUST NO WAY WE CAN ALWAYS BE WATCHING HIM."

THE FACTS:

PHYSICAL RESTRAINTS CANNOT BE USED FOR THE NURSING HOME'S CONVENIENCE.

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

Under the Nursing Home Reform Law, a physical restraint can be used only to treat a resident's medical conditions or symptoms. Restraints never can be used for discipline or the nursing home's convenience.¹⁰ A nursing home must suggest less restrictive methods of managing any problem for which restraints are being recommended. 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 use of physical restraints has dropped drastically over the past twenty-five years; many nursing homes now function completely restraint-free. Part of this decline certainly is due to the Reform Law, but another part comes from a growing medical consensus that restraints harm residents. 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 may also be devastating—understandably, a resident can be frustrated and humiliated by being tied up and unable to move.

Like any type of medical intervention, physical restraints require the consent of the resident or (if the resident does not have the mental capacity to consent) the resident's representative. If the resident's doctor recommends restraints, the resident or resident's representative decides whether to accept or reject that recommendation. That choice should be made with knowledge of restraints' potentially negative consequences.

HOW TO LIMIT USE OF RESTRAINTS

The most important protection is the rule that restraints require consent. You, the reader, cannot be restrained without your permission, and that would remain true if you moved tomorrow into a nursing home. Thus, whenever restraints are suggested, the ultimate decision rests with the resident or (more likely) the resident's representative.

If the nursing home recommends restraints to prevent a resident from wandering, the resident's representative should just say no. First, of course, restraints require a doctor's order, not just a nursing home's recommendation. Also, in this case, restraints evidently are intended 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 offering meaningful activities to combat boredom and absorb 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 a wheelchair? Although the restraint likely will be presented as a way to prevent harm, remember that the restraint instead may cause the resident to become weaker and more susceptible to injury. Remember also the psychological impact of restraints, and the possibility of a horrible accident.

If and when restraints are recommended, a resident's representative should request a care plan meeting (see "Failing to Take Care Planning Seriously"). The care planning process is a good opportunity to discuss the pros and cons of restraints, and to examine possible alternatives.

If a nursing home has imposed restraints without consent, the resident or resident's representative should immediately demand that the restraints be removed. A written demand can be powerful, and should focus on the consent requirement and on how the nursing home commits false imprisonment or battery (an unlawful touching) by imposing restraints without permission. The demand can be submitted to a nurse and/or the nursing home's Grievance Official (see page 9).

Problem #6: Improper Use of Behavior-Modifying Drugs

WHAT YOU HEAR:

“YOUR MOTHER NEEDS DRUGS TO MAKE HER MORE MANAGEABLE.”

THE FACTS:

BEHAVIOR-MODIFYING DRUGS CAN BE USED ONLY IF THE RESIDENT OR RESIDENT’S REPRESENTATIVE CONSENTS, AND ONLY IF THE DRUG’S USE IS NOT FOR THE NURSING HOME’S CONVENIENCE.

Under the Reform Law, a behavior-modifying drug—called a “psychotropic” drug—can be used only to treat a specific condition. Behavior-modifying drugs cannot be used for discipline or the nursing home’s convenience.¹¹

Like any other drug, a behavior-modifying drug 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 the resident’s doctor recommends behavior-modifying drugs, 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.

HOW TO PREVENT INAPPROPRIATE USE OF BEHAVIOR-MODIFYING DRUGS

This guide’s advice on psychotropic drugs largely parallels its advice regarding physical restraints (see “Improper Use of Physical Restraints”). The key point, again, is that a medical intervention (such as a restraint or a drug) cannot be performed without consent from the resident or resident’s representative. Also, care planning is again crucial: drugs should be a last resort, and a care planning meeting is the best place to discuss and consider non-drug-related options.

If a psychotropic drug is being administered without permission, the resident or representative should demand immediately that the drug be discontinued. The demand should be in writing, and emphasize how the nursing home has put itself in legal jeopardy by administering a drug without consent. Submit this demand to the director of nursing and the nursing home’s Grievance Official (see page 9).

In nursing homes, the most powerful behavior-modifying drugs are the antipsychotics (see listing in box on next page). Antipsychotics generally are approved by the federal Food and Drug Administration (FDA) only to treat psychiatric disorders such as bipolar disorder, and often carry warnings that use of the drugs may increase the risk of death among older persons with dementia. Regardless, antipsychotic drugs often are used “off-label” (beyond the FDA-approved situations) in nursing homes to sedate residents who have dementia but not a psychiatric diagnosis.

Through a National Partnership to Improve Dementia Care in Nursing Homes, the federal government is attempting to reduce or eliminate the use of antipsychotic drugs in nursing homes,

but many nursing homes still rely inappropriately on antipsychotics. The [Care Compare website](#) lists the rate of antipsychotic use for each nursing home in the country.

Remember: control rests with the resident or resident representative, since a drug cannot be administered without consent. Before consenting to an antipsychotic or any other behavior-modifying drug, residents and representatives should demand a full and careful discussion of non-drug-related strategies. Rather than administering a psychotropic drug for a resident’s “agitation,” for example, the nursing home staff may want to speak to the resident differently, or provide activities that make the resident more comfortable. Good dementia care requires listening to a resident and recognizing individual needs.

In deciding whether use of a particular drug is advisable, a good rule of thumb is to consider whether the drug’s use is intended to treat a diagnosed health problem, or to keep the resident more manageable. If the benefit is to the resident, then use of the drug may be advisable. If, on the other hand, use of the drug would be largely for the nursing home’s benefit—for example, to keep the resident quiet and out of the way—then the drug likely should be refused.

<h2>Drug vs. Non-Drug Behavioral Management</h2>	
<p>Examples of Antipsychotic Drugs (Brand Name and Generic Equivalent)</p> <ul style="list-style-type: none"> ○ Clozaril (clozapine) ○ Haldol (haloperidol) ○ Risperdal (risperidone) ○ Seroquel (quetiapine) ○ Thorazine (chlorpromazine) ○ Zyprexa (olanzapine) 	<p>Examples of Non-Pharmaceutical Strategies</p> <ul style="list-style-type: none"> ○ Music ○ Approaching residents from the front, taking care not to startle them ○ Supervised trips outside the nursing home ○ Observation and care planning to identify what might be triggering a resident’s distress ○ Activities specifically tailored for the resident’s interests ○ Greater levels of exercise ○ Pets

Problem #7: Eviction Without Proper Notice

WHAT YOU HEAR:

“YOU HAVE TO MOVE OUT IN THREE DAYS.”

THE FACTS:

A NURSING HOME MUST GIVE ADVANCE WRITTEN NOTICE OF A PROPOSED EVICTION, AND THE RESIDENT HAS THE RIGHT TO APPEAL.

Improper evictions are a longstanding problem in nursing homes across the country. For that reason, this guide discusses eight common problems related to eviction (see Problems #7 through #14).

The Nursing Home Reform Law allows eviction only for six reasons:

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.¹²

If a nursing home believes that it has grounds to evict a resident, it must give a written notice to the resident and resident’s representative in a language that the resident and representative understand. The notice must include the alleged reason for the eviction, the planned eviction date, the location to which the resident will be transferred, an explanation of the resident’s appeal rights, and contact information for the long-term care ombudsman program. In general, the notice must be given at least 30 days before the planned eviction, although in some cases a shorter notice period is allowed.

If the resident appeals, a hearing officer decides whether the nursing home will be allowed to carry out the eviction. Hearing procedures vary from state to state. Often the hearing is held in the nursing home; in some cases, the hearing is conducted over the phone.

How to Challenge an Eviction

There are two simple steps in challenging an eviction:

1. **Don't move out!**
2. **Request an appeal hearing.**

The “don't move” advice seems obvious but, in fact, many residents panic and move out after receiving a notice. Residents should resist any such sense of panic. Residents win most appeal hearings (with state-to-state variance), and there generally is little downside to remaining in the nursing home and requesting a hearing.

The request for hearing generally should be made to the designated state agency, which should be identified in the eviction notice. If the notice does not include the necessary information, the resident or representative should make phone calls or do internet research to identify the correct phone number or e-mail address. Understand that the agency conducting the hearings may or may not be the same agency that investigates complaints against nursing homes. The resident is requesting a transfer/discharge hearing, which is not the same as filing a complaint.

More information is available from Justice in Aging's Toolkit for Fighting Nursing Home Evictions. [The Toolkit](https://justiceinaging.org) is found at justiceinaging.org — select Our Work, then Health Care, Long Term Services and Supports, and finally Nursing Facilities. The Toolkit offers all of the following:

- o Explanation of the basics of nursing home evictions.
- o Individual fact sheets for seven common types of evictions.
- o Draft legal briefs for defending a resident at a transfer/discharge hearing, to push back against five common claims made by facilities.
- o Draft legal documents for seeking a court order forcing a nursing facility to allow a resident to return from a hospitalization.

Problem #8: Eviction for Being ‘Difficult’

WHAT YOU HEAR:

“YOU MUST MOVE OUT BECAUSE YOU ARE TOO DIFFICULT.”

THE FACTS:

A NURSING HOME MUST PROVIDE NECESSARY CARE WHETHER A RESIDENT IS “EASY” OR “DIFFICULT.”

As mentioned immediately above (see “Eviction Without Proper Notice”), a nursing home can evict a resident only for one of six reasons. Notably, being “difficult” is *not* one of those six reasons. Don’t forget: nursing homes exist in order to care for people with physical and cognitive problems. Many nursing home residents are “difficult” in one way or another.

Consider an example. Some nursing homes may attempt to evict a resident who tends to wander aimlessly, or who has severe dementia and is making loud sounds during the night. Such evictions almost always are improper, because a nursing home is an appropriate environment for these residents. 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 they can be transferred to another.

A nursing home may argue that it cannot meet the needs of the supposedly “difficult” resident. This argument is wrong, because a can’t-meet-your-needs eviction only applies if the resident’s needs cannot be met in a nursing home generally—for example, if the resident needs care available only in a subacute unit or a locked psychiatric ward. A nursing home cannot use its own inadequate care to justify eviction.

Some Improper Justifications for Eviction

- Resident is difficult.
- Resident requires too much staff attention.
- Resident’s care is too costly.
- Caring for resident prevents staff from caring adequately for other residents.
- Resident requires two-person assistance with transferring.
- Resident does not follow the nursing home’s policies.

HOW TO CHALLENGE EVICTION FOR BEING ‘DIFFICULT’

First, follow the two basic steps from Problem #7: don’t move, and request a 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 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 (see “Failing to Take Care Planning Seriously”), and instead initiated eviction 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 actually 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 the current nursing home could not do the same.

For a cannot-meet-your-needs eviction, federal regulations require that the resident’s doctor document the resident’s unmet needs at the nursing home, the nursing home’s attempts to meet those needs, and the ability of the proposed new facility to meet those needs.¹³ If the nursing home does not have this documentation, that failure by itself is reason enough for ruling in the resident’s favor. If, on the other hand, the nursing home has the documentation, the resident, representative, or attorney should poke holes in its reasoning—pointing out, for example, that the current nursing home should be able to provide the same care that the proposed “new” facility would provide.

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.” Actually, 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 themselves receiving more respect and better care.

DON’T LET THE RESIDENT BE BLAMED FOR HAVING DEMENTIA

Many attempted evictions boil down to criticizing the actions of a resident with dementia. But nursing homes exist to serve persons with dementia. In good dementia care, the nursing home pays close attention to the resident’s needs and actions, and uses the care planning process to meet those needs.

Problem #9: Eviction for Complaining

WHAT YOU HEAR:

“YOU COMPLAIN ABOUT HOW POOR THE CARE IS HERE, SO YOU CAN BE EVICTED UNDER THE REASON THAT THE NURSING HOME CANNOT MEET YOUR NEEDS.”

THE FACTS:

A RESIDENT CANNOT BE PENALIZED FOR MAKING A COMPLAINT, AND A NURSING HOME CANNOT JUSTIFY EVICTION BY PROVIDING SUBSTANDARD CARE.

The nursing home here is justifying eviction by claiming that it cannot meet the resident’s needs. As discussed immediately above (see “Eviction for Being ‘Difficult’”), a “cannot meet your needs” claim should be measured by what a nursing home is required to do under the law, and not by the nursing home’s potentially deficient care. If a nursing home is required by law to provide the needed care, then the nursing home cannot base an eviction on being unable to meet the resident’s needs.

As discussed above, if a nursing home claims that it cannot meet the resident’s needs, the resident’s doctor must document the resident’s unmet need(s), the nursing home’s attempts to meet the resident’s needs, and the ability of a proposed new nursing home to meet those needs.

Of course, there is also something particularly unseemly in a nursing home weaponizing the resident’s care complaints to justify eviction. In general, a resident’s complaints should lead to the nursing home improving its care, rather than evicting the resident. Also, a resident has a right to make requests and complaints without retaliation.¹⁴

HOW TO CHALLENGE EVICTION FOR MAKING COMPLAINTS

First, the resident follows the two basic steps: don’t move out, and request a hearing. Before and during the hearing, emphasize the resident’s right to make a complaint without reprisal. The hearing officer should recognize the unfairness of the resident requesting more or better care, and then having that legitimate request being used to justify eviction.

Remember also the documentation requirements for all cannot-meet-your-needs evictions. The resident’s doctor must document the resident’s unmet need(s), the nursing home’s efforts to meet those needs, and the ability of the proposed new nursing home to meet those needs. A nursing home’s failure to provide this document should be, by itself, reason enough for a hearing officer to rule for the resident.

Problem #10: Eviction for Refusing Medical Treatment

WHAT YOU HEAR:

“YOU MUST MOVE OUT BECAUSE YOU ARE REFUSING MEDICAL TREATMENT.”

THE FACTS:

A RESIDENT HAS A RIGHT TO REFUSE MEDICAL TREATMENT. BY ITSELF, REFUSAL OF TREATMENT IS NOT AN ALLOWABLE REASON FOR EVICTION.

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

As discussed above (see “Eviction Without Proper Notice”), eviction is only allowed for one of six reasons. Federal nursing home guidelines state: “Resident decisions to refuse care should not be considered a basis for transfer or discharge unless the refusal poses a risk to the resident’s or other individuals’ health and/or safety.”¹⁵

On occasion, residents refuse treatment because they are terminally ill and do not want to take steps to extend life. This is their right, and they 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 the resident’s admission.

HOW TO CHALLENGE EVICTION FOR REFUSING MEDICAL TREATMENT

Following the procedures discussed above in Problems #7 and #8, 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 refusing treatment does not endanger others, and why the resident does not need a higher level of care (such as a hospital or subacute unit).

A draft legal brief on these issues is available in the [Toolkit for Fighting Nursing Home Evictions](#) (see page 20 for details on the toolkit).

Problem #11: Eviction for Nonpayment While Medicaid Application Is In Process

WHAT YOU HEAR:

“YOU OWE US FOR SEVERAL WEEKS OF CARE, AND WE CAN’T WAIT FOR MEDICAID TO BE APPROVED.”

THE FACTS:

A NURSING HOME CANNOT EVICT FOR NONPAYMENT WHILE A THIRD-PARTY PAYOR IS CONSIDERING A CLAIM.

The federal regulations contain two important resident protections against nonpayment evictions. First, a nursing home cannot evict for nonpayment unless the resident first has received reasonable and appropriate notice of the amount supposedly owed. Second, eviction for nonpayment is not allowed while the Medicaid program (or another third-party payor) is considering a claim for payment.¹⁶

HOW TO CHALLENGE NONPAYMENT EVICTION WHEN MEDICAID APPLICATION IS PENDING

Again following the procedures discussed above in Problems #7 and #8, a resident or resident’s representative should request an appeal hearing.

A discussion with the nursing home may also bear fruit. Citing the law discussed above, the resident or representative should explain to the nursing home that the nursing home is not allowed to evict for nonpayment while a Medicaid application is pending. The law simply reflects residents’ reality: since they presumably have spent savings down to Medicaid eligibility levels, they cannot afford the nursing home’s private-pay rate.

As a showing of good faith, a resident may choose to estimate and pay the Medicaid patient pay amount for the relevant months. (The “patient pay amount” is the share of the resident’s income that must be paid each month to the nursing home, once Medicaid is approved.) After all, if and when the application is approved, most unmarried residents (and some married residents) will be required to pay a patient pay amount. In some cases, furthermore, failure to pay a patient pay amount for several months may cause problems for the resident by allowing the resident’s savings to rise above the low limit (often \$2,000) set by Medicaid eligibility rules.

A draft legal brief on these issues is available in the [Toolkit for Fighting Nursing Home Evictions](#) (see page 20 for details on the toolkit).

Problem #12: Eviction Because Medicare Payment Has Ended

WHAT YOU HEAR:

“WE ARE A SHORT-TERM REHABILITATION FACILITY, AND YOU NEED LONG-TERM CHRONIC CARE.”

THE FACTS:

A NURSING HOME CANNOT LIMIT ITSELF TO SHORT-TERM, MEDICARE-FUNDED RESIDENTS.

Medicare pays a relatively high rate—but generally only for a few weeks (see “A Brief Introduction to Medicare, Medicaid & Medicare Advantage” page 6). In response, some cynical nursing homes follow a business model that emphasizes bringing in residents for Medicare payment but then, when Medicare payment ends, pushing those residents out to be replaced with new Medicare-funded residents. Then, of course, the process repeats itself, with residents continually being brought in for their Medicare payment, but then discarded when Medicare payment ends.

This strategy clearly violates the Nursing Home Reform Law. Under the no-financial-discrimination rule (Problem #1), a change in payment source must not lead to eviction. And change in payment source is not one of the six legitimate reasons for eviction (Problem #7).

HOW TO CHALLENGE EVICTION WHEN MEDICARE PAYMENT ENDS

In facing a possible eviction driven by the end of Medicare coverage, first consider whether and how to appeal for additional coverage by Medicare or a Medicare Advantage plan (see Problems #16 through #20 for more information).

Then, if coverage by Medicare or a Medicare Advantage plan is ending, follow the two simple steps set out in Problem #7: don’t move out, and request an appeal hearing. In the hearing, the resident or representative should emphasize that the resident has paid or is prepared to pay for the nursing home stay, through either Medicaid or private payment. One caveat: if a state allows for partial Medicaid-certification, a Medicaid-eligible resident may have to be strategic to access a Medicaid-certified bed. Consult Problem #15 for more information on how to handle this issue.

As a practical matter, the short-stay-only eviction almost never reaches the hearing stage—because the nursing home has no legitimate argument. The real decision-point occurs when the nursing home falsely claims that a resident must move out. If residents panic and leave, they lose. But if they stay put, the nursing home generally will change its tune and accept the residents’ payment.

Problem #13: Eviction to an Unsafe Setting

WHAT YOU HEAR:

“YOU WILL BE TRANSFERRED TO YOUR DAUGHTER’S HOUSE.”

THE FACTS:

A NURSING HOME MUST TRANSFER THE RESIDENT TO A SAFE, APPROPRIATE SETTING.

Even if an eviction is otherwise legitimate, it should not be carried out if the resident would be put in an unsafe situation. An eviction notice must include the location to which the resident would be transferred, and that location must be appropriate. Also, the nursing home must provide adequate preparation and orientation to ensure a safe transfer. Especially if the transfer will be made to a non-nursing-home setting, the nursing home must consider the availability of caregivers and other support persons.

HOW TO CHALLENGE INADEQUATE TRANSFER PLANNING

A resident or representative can cite discharge planning requirements as a defense in an eviction hearing. A nursing home’s poor discharge planning is reason enough for a ruling in the resident’s favor, even if otherwise the nursing home has grounds for eviction.

In defending improper eviction notices, nursing homes often argue “no harm, no foul.” Since the resident made an appeal, the nursing home argues, any inadequacy in the notice is now meaningless. But the resident should push back hard against this argument, which ignores the many residents who do not appeal after receiving faulty notice. To promote honest practices among nursing homes, a hearing officer should rule in the resident’s favor whenever notice has been inadequate. Otherwise, the nursing home would benefit from a heads-I-win, tails-you-lose situation: giving faulty notice and winning automatically when a resident does not appeal, but suffering no repercussions when a resident raises faulty notice in a hearing.

Problem #14: Eviction While Resident Is Hospitalized

WHAT YOU HEAR:

“WE WON’T TAKE YOU BACK FROM THE HOSPITAL.”

THE FACTS:

A MEDICAID-ELIGIBLE RESIDENT HAS THE RIGHT TO RETURN TO THE NEXT AVAILABLE MEDICAID-CERTIFIED BED. A NURSING HOME MUST ALLOW THE RESIDENT TO RETURN WHILE WAITING FOR AN EVICTION HEARING.

When a resident is hospitalized, state law generally requires the nursing home to hold the bed for a week or two, if the resident wants to return to the nursing home. The maximum bed hold length varies from state to state.

Residents paying privately must pay for a bed hold themselves. For Medicaid-eligible residents, the Medicaid program generally will cover the expense.

But a resident’s right to return is not limited to bed holds. If, after return, the resident’s nursing home bill would be paid through Medicaid or Medicare, they have the right to return to the previous bed in the nursing home, if that bed is available. Otherwise, the resident must be given the next available bed. A bed is only considered available if it is certified for the payment type (Medicaid or Medicare) that the resident will be using.¹⁷

This protection makes good sense. Paying to “hold” a nursing home bed for a long period may be too expensive for either a resident or a Medicaid program. But there is no extra expense in guaranteeing that a hospitalized resident can return to a bed that otherwise would be vacant.

Although a nursing home may serve an eviction notice while a resident is hospitalized, the notice does not limit the resident’s right to return to the nursing home after the hospitalization. If a resident requests an eviction hearing, they can return to and stay in the nursing home while waiting for the hearing.¹⁸ The nursing home must accept the resident back even if the nursing home is alleging that it can’t meet the resident’s needs, or that the resident owes money.

HOW TO RETURN TO THE NURSING HOME

A resident should not hesitate to assert the right to return to the next available bed. And the resident should not relent even if the nursing home claims that it has no vacancy. The resident has a claim to the next available bed, so should check back every day. If the nursing home understands that the resident will keep checking and checking for the next available bed, the nursing home more likely will accept the inevitable and allow the resident to return.

Sometimes a nursing home plays hardball and simply refuses to accept the resident back after a hospitalization. These situations require prompt, strong action. Soon enough, the hospital will be looking to discharge the resident, which imposes significant time pressure on the resident or advocate. The resident can cite this guide and the relevant provisions from the Code of Federal Regulations.

The resident may want to enlist the assistance of the local ombudsman program. If the nursing home doesn't budge, the resident can file an urgent complaint with the state's nursing home inspection agency. When making the complaint, the resident should emphasize the need for immediate action, and clearly distinguish the complaint from any separate request for an eviction hearing. In response to the complaint, the inspection agency can cite the nursing home and impose sanctions (money penalties, etc.) to force the nursing home to allow the resident's return.

In addition, the resident may wish to seek an immediate court order against the nursing home. To go this route, the resident should consult with a knowledgeable local attorney. The resident's predicament may well be sympathetic to a judge and, as explained above, the law likely will be in the resident's favor. Draft legal documents for seeking a court order are available in the [Toolkit for Fighting Nursing Home Evictions](#) (see page 20 for details on the toolkit).

Problem #15: Refusal to Accept Medicaid

WHAT YOU HEAR:

“YOU MAY BE MEDICAID-ELIGIBLE NOW, BUT WE DON’T HAVE A MEDICAID BED FOR YOU.”

THE FACTS:

A NURSING HOME CAN CERTIFY ADDITIONAL BEDS FOR MEDICAID PAYMENT.

Some states allow a nursing home to certify only a portion of its beds for Medicaid payment. Such partial certification creates a particular problem when a resident initially pays the private-pay rate, but later becomes Medicaid-eligible by spending savings down to Medicaid limits.

At that point, if the resident is not in a Medicaid-certified bed, the nursing home may claim that it cannot accept Medicaid payment for the resident’s care. This could lead to nonpayment and then eviction, because the resident will have spent down savings and be unable to pay the private-pay rate.

The resident or resident’s representative should understand that the nursing home actually is not being “forced” to bill at the private-pay rate—it has options. The nursing home could transfer the resident to a Medicaid-certified bed. Or, if no Medicaid-certified bed is available, the nursing home could request certification of additional beds. Even if a state allows partial Medicaid certification, a nursing home is entirely free to seek certification for each and every bed.

HOW 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 before admission, as part of choosing the nursing home. As soon as possible, the resident (or resident’s representative) should determine if the nursing home accepts Medicaid payment, and if Medicaid certification is full or partial. After admission, the resident should determine whether the current bed is Medicaid-certified. Remember that some states require Medicaid-certified nursing homes to certify each and every bed for Medicaid payment.

General information about a nursing home’s certification is available on the federal government’s [Care 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 the nursing home’s information.

If a resident foresees themselves in the situation discussed earlier in this problem—being financially eligible for Medicaid, but in a bed not certified for Medicaid—they, as soon as possible, should request transfer to a Medicaid-certified bed. If no Medicaid-certified bed is available, the resident should ask that the nursing home seek certification of the current bed or other specified beds in the nursing home. Ideally, the resident should make this request from four to six months before becoming financially eligible for Medicaid, although a lesser amount of time should be enough for the nursing home to line up a Medicaid-certified bed. If the nursing home fails to comply, the resident may wish to file a grievance (see page 9).

In making these requests, the resident puts the nursing home on notice that Medicaid coverage will be necessary. In most cases, in order to avoid disputes, the nursing home will arrange for the necessary Medicaid-certified bed. If the nursing home fails to do so, and instead tries to evict the now Medicaid-eligible resident for nonpayment, the resident in an eviction hearing will have a strong argument that any nonpayment is the nursing home's fault.

Eviction procedures and appeals are discussed in problems #7 through #14.

Problem #16: Refusal to Bill Medicare

WHAT YOU HEAR:

“WE HAVE DETERMINED THAT YOU AREN’T ENTITLED TO MEDICARE COVERAGE BECAUSE OF YOUR LIMITED HEALTH CARE NEEDS.”

THE FACTS:

A RESIDENT CAN INSIST THAT THE NURSING HOME BILL MEDICARE.

Medicare is not a comprehensive health insurance program—it has holes. One common limitation is that Medicare coverage often depends upon a link to hospital care. For nursing home care, the Medicare program can pay only when the resident 1) enters the nursing home within 30 days after a hospital stay of at least three nights, and 2) needs care related to the hospitalization. One thing to look out for: any night spent in “observation status” (rather than inpatient status) does not count toward the three-night requirement. (Note: The three-night requirement is waived during the ongoing COVID-19 emergency period.)

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 \$194.50 (for 2022; it rises slightly year to year). This co-payment is covered by most Medicare Supplement insurance policies, often called “Medigap” policies.

These benefits renew themselves in each benefit period. A new benefit period starts when a resident has not used Medicare payment either for hospital care or nursing home care for at least 60 days. (Note: During the ongoing COVID-19 emergency period, the benefit period can renew immediately, without the 60-day wait, if the emergency has prevented the benefit period from being renewed.)

PROBLEMS WITH OBSERVATION STATUS HOSPITAL STAYS

Unfortunately, some hospital admissions are classified as “observation status” for Medicare purposes. The patient technically is not admitted, and instead receives “outpatient” services, even if they are in the hospital for several days. If a patient is expected to receive observation services for more than 24 hours, the hospital must provide a Medicare Outpatient Observation Notice within 36 hours of the start of the hospital stay. When observation status is threatened or has begun, patients and their families should advocate with the doctor to change course and classify the patient as an inpatient.

There is one additional limitation, and this is the limitation that disqualifies most residents from Medicare-funded nursing home care. If a resident needs only “custodial care”—for example, administering drugs, or routine wound care—Medicare will not pay. Payment under Medicare is possible only if the resident needs skilled nursing services or skilled therapy. These skilled services generally must be needed every day, although an exception can allow for Medicare payment even if therapy is provided only five days per week. Common therapies are physical therapy and speech therapy.

“Skilled” services require significant, direct participation of a nurse or licensed therapist. It is not enough that a nurse is administering drugs or overseeing the resident’s care.

Notice procedures vary depending on whether a resident is receiving traditional Medicare coverage, or whether coverage is provided through a Medicare Advantage plan. Traditional Medicare is discussed in this problem; Medicare Advantage is discussed in Problem #17.

Under traditional Medicare, if a resident is a Medicare beneficiary who recently concluded a hospital stay of at least three nights, the nursing home must notify the resident in writing through the “Skilled Nursing Facility Advance Beneficiary Notice” whenever the nursing home first decides that it will not bill Medicare for the resident’s care. Thus, this notice may be given when the resident first is admitted or later, after Medicare has paid for some nursing home care.

Here is the most important fact: the resident can insist that the nursing home submit a bill to Medicare. If the nursing home has given the Advance Beneficiary Notice properly, the resident can return the notice to the nursing home after checking a box that requests that the nursing home bill Medicare for the resident’s care. If the nursing home has failed to give the required notice, the resident nonetheless can submit a separate written request that the nursing home bill Medicare.

While the Medicare program is considering a submitted bill, the nursing home may not charge the resident for any amount that Medicare subsequently may pay. If Medicare refuses to pay, the resident becomes financially liable, but has the right to further appeal (to an administrative law judge, the Medicare Appeals Council, and ultimately a federal court). While an appeal is pending, however, the resident will continue to be financially responsible, unless the resident has separate coverage through Medicaid or another payor (see “A Brief Introduction to Medicare, Medicaid & Medicare Advantage” page 6).

HOW TO OBTAIN MEDICARE ELIGIBILITY

These issues arise most commonly in therapy. Assume that a resident is recovering from a broken hip. They will want therapy in order to regain the ability to walk. In such cases, prompt therapy is crucial. If therapy is not provided, or 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 submit bills for just a few days or weeks of services. 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 Medicare, and convince the doctor (or therapist) to continue ordering (or recommending) therapy services. Battle on the first front is relatively easy—as explained above, the resident can require the nursing home to submit a bill to Medicare.

But submitting a bill is futile unless the resident actually receives the qualifying therapy services. The resident (or resident’s representative) should encourage the doctor or therapist to initiate and continue appropriate therapy. The resident or representative may find a receptive audience, since the doctor or therapist may be just as frustrated as the resident by the forces discouraging necessary therapy. The message to the doctor or therapist should be simple: please focus on medical considerations and let the resident or representative handle Medicare-related issues. If necessary, the resident may want to switch doctors, if a second doctor is more willing to order therapy.

If a doctor orders therapy, the nursing home must ensure that it happens. A nursing home always must follow a doctor’s orders, assuming that the resident or representative consents to the order.

The resident’s two advocacy steps—advocating with the nursing home, and with the doctor and/or therapist—reinforce each other. If the nursing home is required to submit a bill, the nursing home has every incentive to provide the resident with services that justify Medicare payment. Similarly, if the doctor or therapist is persuaded to provide therapy services, each has an interest in Medicare’s paying for those services.

Problem #17: Refusal to Pay by Medicare Advantage Plan

WHAT YOU HEAR:

“YOUR MEDICARE ADVANTAGE PLAN WON’T PAY BECAUSE YOU NEED ONLY CUSTODIAL CARE.”

THE FACTS:

RESIDENTS CAN APPEAL MEDICARE ADVANTAGE DENIALS.

Many Medicare beneficiaries have chosen to receive Medicare benefits through managed care plans, called Medicare Advantage. A Medicare Advantage plan must provide at least the same level of coverage available under regular Medicare. In addition, in order to attract members, most Medicare Advantage plans offer extra benefits beyond what Medicare requires.

What’s the catch? When enrolling in a Medicare Advantage plan, the beneficiary is limited to the health care providers (doctors, nursing homes, etc.) in the plan’s network. Another catch: the Medicare Advantage plan makes initial coverage determinations and sometimes has a financial incentive to deny care. A Medicare Advantage plan generally is paid a fixed monthly rate by Medicare for each member. Denying care might reduce expenses and thereby increase the plan’s profitability.

Because of Medicare rules, Medicare Advantage coverage for nursing home care is closely related to regular Medicare coverage rules. (For more information about Medicare coverage rules, see page 32.) The Medicare Advantage plan must offer nursing home coverage to members who

have received inpatient care in a hospital for at least three nights, and who need skilled nursing care or therapy on a daily or almost-daily basis. Plans have some flexibility to improve coverage—for example, by eliminating the three-night stay requirement. Some plans increase the maximum days of coverage beyond 100; others may limit or eliminate the daily co-payments that traditional Medicare imposes for days 21 through 100. (Note: The three-night requirement has been waived during the ongoing COVID-19 emergency period, to reduce any incentive that a person remain in a hospital any longer than necessary.)

OBSERVATION STATUS PRESENTS PROBLEMS IN MEDICARE ADVANTAGE

As discussed in Problem #16, nights in the hospital do not count for Medicare nursing home coverage if the patient was in observation status rather than inpatient status. The hospital's notice requirements are the same whether the patient receives traditional Medicare or Medicare Advantage—in either case, the hospital must notify the patient if observation status will last more than 24 hours. The patient and family should advocate to have the hospital stay reclassified as inpatient.

WHAT TO DO WHEN MEDICARE ADVANTAGE PLAN STOPS PAYMENT FOR NURSING HOME SERVICES

The basic advice is simple: appeal incorrect decisions. As much as possible, fortify your appeal requests with information from health care professionals and the resident's medical records.

A Medicare Advantage plan must give two-day advance written notice when stopping payment for nursing home services. This notice must explain how the resident can appeal to the local Quality Improvement Organization (QIO), an independent agency paid by the federal government to decide appeals and monitor quality. The resident must file the appeal by the day before the proposed last day of coverage. Once the resident appeals, the Medicare Advantage plan must provide a detailed explanation of why Medicare coverage supposedly is improper. To counter this information, the resident or representative should inform the QIO why the plan is wrong. Written information is best, but not required.

The QIO must make its decision by no later than the proposed last day of coverage. A favorable decision requires the plan to continue payment. If, however, the QIO rules against coverage, the resident can pursue the matter further by requesting reconsideration by the QIO, and then appealing to an administrative law judge, the Medicare Appeals Council, and a federal court. During these further appeals, however, the resident will be responsible for paying for nursing home care, but with a right to reimbursement if they ultimately win.

As always, the expert opinion of a doctor, therapist, or other health care professional is essential. Unfortunately, doctors or therapists sometimes may be less willing to support residents in a Medicare Advantage situation, since the doctors or therapists likely have contracts with the Medicare Advantage plan. Also, remember that appeal is futile unless the resident actually receives the skilled services at issue.

Procedures are somewhat different when the Medicare Advantage plan denies coverage from the very start (as opposed to providing coverage, then stopping it). The resident requests

an appeal from the Medicare Advantage plan, rather than a QIO. The resident should request expedited review, which requires the Medicare Advantage plan to issue a decision within 72 hours. Again, the resident or representative is well advised to submit information in writing, and to solicit support from a doctor, therapist, or other health care professional.

Problem #18: Losing Therapy for Supposed Failure to Make Progress

WHAT YOU HEAR:

“WE MUST DISCONTINUE THERAPY BECAUSE YOU AREN’T MAKING PROGRESS.”

THE FACTS:

THERAPY OFTEN IS APPROPRIATE EVEN IF A RESIDENT IS NOT MAKING MEASURABLE PROGRESS.

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

Most likely, the real reason behind termination is both medical and 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.

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, they likely will have good days and bad days. If they were to walk 15 feet unassisted, therapy could be advisable if a week later the resident 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, maintains, or slows the decline of the resident’s condition.

If terminating therapy is blamed on Medicare rules, the resident has two strong responses. First, as explained in this guide’s discussion of Problem #1, a nursing home must provide the same high quality of care no matter how the bill is paid—whether through private funds, Medicare, or Medicaid.

Second, the Medicare program can pay for therapy services even if the resident is not improving. 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.¹⁹

These points are emphasized by the federal government in their "[Jimmo Settlement](#)" webpage.²⁰ The government acknowledges that many persons have "erroneously believed" that improvement is required, and then explains that Medicare can cover therapy "to maintain function or to prevent or slow decline or deterioration."

WHAT TO DO WHEN TOLD THAT RESIDENT HAS 'PLATEAUED'

First consider the procedures under traditional Medicare (as opposed to Medicare Advantage). The resident generally receives official notice of "plateauing" through a Notice of Medicare Non-Coverage, which must be given to the resident at least two days before the proposed end of Medicare payment. The resident has the right to request an immediate appeal with that area's Quality Improvement Organization (QIO), which is an independent agency contracted with the Medicare program to hear consumer appeals. If the resident appeals, the nursing home must provide a detailed explanation of why Medicare payment supposedly is improper. The QIO representative then will seek input from the resident or representative, and rule on the appeal within a day or two.

If the QIO rules for the resident, Medicare payment continues. If, however, the QIO rules against the resident, the resident has the right to a further appeal with a different independent agency that has a very similar name, the Qualified Independent Contractor (QIC). The QIC should issue a decision within three days. If the resident loses, they may be liable for nursing home expenses incurred while the QIC was considering the appeal, if the nursing home had notified the resident of potential liability through a Skilled Nursing Facility Advance Beneficiary Notice (the same notice discussed in Problem #16). Further appeals are possible to an administrative law judge, the Medicare Appeals Council, and a federal court although, again, the resident bears financial responsibility while the appeal is pending.

At any level of appeal, the resident will want to retain the support of the doctor and therapist, and encourage them be conscientious in documenting the resident's need for therapy. 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 benefit a resident, even if the resident declines somewhat, then therapy should be provided. This is good medicine, and consistent with relevant Medicare rules.

These same principles apply to Medicare Advantage: "plateauing" should not be justification for terminating therapy, and support of a doctor and/or therapist is vital. Follow the appeal procedures described above in Problem #18.

Information from the government's Jimmo Settlement webpage can be very persuasive. Additional helpful information is available from the [Center for Medicare Advocacy website](#), which represented nursing home residents against the federal government in the *Jimmo v. Sebelius* court case.

Problem #19: Losing Therapy After Medicare Payment Has Ended

WHAT YOU HEAR:

“WE CAN’T GIVE YOU THERAPY BECAUSE MEDICARE COVERAGE HAS EXPIRED, AND MEDICAID DOESN’T PAY FOR THERAPY.”

THE FACTS:

THERAPY MUST BE PROVIDED WHENEVER ORDERED BY A DOCTOR, REGARDLESS OF THE RESIDENT’S SOURCE OF PAYMENT.

Therapy should not stop just because a resident has reached the 100-day limit of Medicare coverage (or any higher limit set by a Medicare Advantage plan). The two reasons have already been discussed. First, a nursing home must provide a resident with medically necessary services. Second, a resident’s services shouldn’t depend on source of payment. Specifically, a Medicaid-eligible resident is entitled to the same level of service provided to other residents (see “Introduction” and Problems #1 and #4 for discussion of these two reasons).

Federal guidelines state clearly that therapy services “are considered a facility service provided to all residents who need them based on their comprehensive plan of care and are included within the scope of facility services.”²¹ In some states, in addition, a nursing home may be entitled to extra Medicaid payment when therapy is provided.

HOW 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 must follow a doctor’s orders. In some cases, the resident may benefit by switching doctors, if the second doctor is more respectful of the resident’s continued need for therapy.

As is the case in Problem #1, the focus must be on the resident’s needs rather than the nursing home’s finances. Do not be drawn into arguments about whether the Medicaid rate is adequate. The nursing home promised the state and federal governments that it would accept the Medicaid rate as payment in full, and has no right to cut corners with individual residents.

Minimal “range-of-motion” exercises generally are not sufficient for a resident who needs active physical therapy.

Problem #20: Forced Transfer from 'Medicare Bed'

WHAT YOU HEAR:

"BECAUSE MEDICARE PAYMENT HAS STOPPED, YOU MUST MOVE FROM THIS 'MEDICARE BED.'"

THE FACTS:

A "MEDICARE BED" IS NOT LIMITED TO MEDICARE-FUNDED RESIDENTS.

A "Medicare bed" is a bed that has been certified for Medicare. 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 a resident assigned to that bed.

But Medicare certification does *not* mean that the bed is reserved exclusively for Medicare-funded residents. A Medicare-certified bed can be occupied by a resident who is paying privately, or through private insurance. In addition, a Medicare-certified bed can be occupied by a resident who is paying through Medicaid, if the bed also is Medicaid-certified. (For more information about Medicaid certification, see page 30.)

Because Medicare generally pays more per day than any other payment source, nursing homes prefer to use Medicare-certified beds for Medicare-funded residents. But, for a finance-focused nursing home, a resident becomes less desirable once Medicare payments end (see this guide's discussion of Problems #16, #17 and #18 for more details). At that point, the nursing home has a financial incentive to move the resident out of the Medicare-certified bed, and move in a different Medicare-funded resident. Weeks or days later, the process repeats, as again a resident is moved out and replaced by a fresh Medicare-funded resident.

Shuttling residents around like this may seem financially advantageous for a nursing home, but shows little respect for residents. It is hardly person-centered (see "Failing to Take Care Planning Seriously") to act as if it doesn't matter in which room a resident lives. The resident may prefer the original room. Also, because Medicare payment is available only to those residents who need therapy or more intensive nursing services, the nursing care provided in the Medicare-certified area may be generally better than the care provided in the rest of the nursing home.

Fortunately for residents, the Nursing Home Reform Law protects residents in these situations. A resident has the right to refuse any transfer within the nursing home if the transfer's purpose is to move the resident out of a Medicare-certified bed.²² This right provides a counterbalance to the Medicare program's transfer-encouraging financial incentives.

Before any transfer within a building, the nursing home must give written notice that includes the reason for the proposed transfer. As mentioned, a resident can refuse a transfer that moves the resident out of a Medicare-certified room. The resident also has the right to refuse any transfer within the nursing home that is designed solely for staff convenience.

HOW TO STAY IN A MEDICARE BED

If a resident does not want to leave a Medicare-certified bed, they should not hesitate to assert the right to refuse the transfer.

If the resident will be relying on Medicaid payment, they should make 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 [Care Compare website](#).²³ More detailed information about the certification of particular beds should be available from the state agency that inspects, certifies and licenses nursing homes (often part of the state's Health Department). The nursing home itself 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 its Medicare-certified beds to be occupied by residents ineligible for Medicare payment. In response, the resident should point out that the nursing home always can certify additional beds for Medicare payment. Nothing prevents any nursing home from seeking Medicare certification for every single one of its beds.

Problem #21: Imposing Visiting Hours on Families and Friends

WHAT YOU HEAR:

“YOUR CHILDREN CAN VISIT ONLY DURING VISITING HOURS.”

THE FACTS:

RESIDENTS CAN ACCEPT VISITORS 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 impose visiting hours on any person visiting with the resident’s consent.²⁴ 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.

A family member or friend can have good reasons to visit outside of “normal” visiting hours. The visitor might work a swing shift and not leave work until 10 p.m. 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 it. If a resident does not want to see a visitor, the visitor has no right to visit.

Under the federal regulations, a nursing home can limit visits from non-family visitors through “reasonable clinical and safety restrictions.” The Surveyor’s Guidelines suggest that these restrictions could restrict visits from persons who have infectious conditions, have been found to have committed “criminal acts such as theft,” or who are drunk or disruptive. If a potential visitor is suspected of abusing or exploiting a resident, the nursing home can limit visits by that person until an investigation is conducted. The results of that investigation determine whether the nursing home can continue to impose restrictions.

HOW TO CHALLENGE VISITING HOUR RESTRICTIONS

If a nursing home claims that visits can be made only during official visiting hours, the resident or potential visitor should let the nursing home know that the Reform Law allows a resident to accept a visit at any time. To back up this argument, the resident or potential visitor should give the nursing home a copy of the law, the accompanying Surveyor’s Guidelines, and/or this guide.²⁵ Remember that the entire concept of visiting hours is inconsistent with the Reform Law’s vision of the nursing home being a true “home” for residents.

VISITING DURING COVID-19 EMERGENCY PERIOD

During the first year-plus of the COVID-19 pandemic, the federal government dramatically restricted nursing home visitation, in an effort to limit spread of the virus. Now, however, a resident's right to receive visitors (as described above) has largely been restored. Residents have the right to receive visits of any length.

A federal [Frequently Asked Questions document](#) (Dec. 2021) explains current policies. To limit COVID risks, visitors are expected to wear masks, wash their hands, and maintain a safe distance from other residents. Also, because physical distancing may be impossible with large groups, a facility can ask visitors to stagger their visits through the day, and also can limit the number of visitors at any one time in the facility or in a resident's room.

In general, residents and their visitors have the right amongst themselves to hug or have other physical contact, or to go without masks. The key, of course, is that other residents not be put at risk. If possible, visits in a resident's room should occur when the roommate is out. If this is not possible, visitors must maintain a safe distance from the roommate.

Problem #22: 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 federal 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. The nursing home also must designate an employee as a liaison with the group, and this employee must be approved by the group. A nursing home must seriously consider, and respond to, all complaints or recommendations made by a resident or family council.²⁶ (Note: During the COVID-19 emergency period, procedures for resident and family councils can be modified to limit the spread of the virus.)

HOW 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 many of the issues discussed in this guide, or any other issue related to the nursing home. Cite the law and this guide in requesting space and support for council meetings.

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.

Examples of Issues to Discuss in Resident or Family Council

- Assistance for residents to travel outside nursing home.
- Adequacy of staffing levels.
- Consistent assignment, i.e., whether direct-service staff generally is assigned to assist same residents.
- Activities.
- Special occasions.
- Meal options.
- Access to food outside mealtimes.
- Access to religious services.

Problem #23: 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 ‘RESPONSIBLE PARTY.’”

THE FACTS:

A NURSING HOME CANNOT REQUIRE ANYONE BUT THE RESIDENT TO BE FINANCIALLY RESPONSIBLE FOR NURSING HOME EXPENSES.

Under the Nursing Home Reform Law, a nursing home cannot request or require that a resident’s family member or friend become financially responsible for nursing home expenses.²⁷ The signature of a family member or friend is allowed only if they are signing for the resident, and committing only the resident’s money. For example, a family member can sign an admission agreement as the resident’s appointed agent, because in that case the resident is financially responsible.

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 \$2,000 (for example), a family member who accepts responsibility for nursing home expenses takes on liability for an unknown amount—maybe \$1,000, or maybe \$50,000, or maybe even more, depending on circumstances.

ILLEGAL AND UNFAIR ADMISSION AGREEMENT PROVISIONS

Financial Guarantees

Some nursing homes use “Responsible Party” signature lines as a way of tricking a family member or friend into becoming financially responsible. 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 may define “Responsible Party” as someone who has full financial responsibility for nursing home expenses. In some cases, the admission agreement states that a “Responsible Party” is required; in other instances, the admission agreement states that the “Responsible Party” is volunteering to be financially responsible.

All such “Responsible Party” provisions are illegal, since the Reform Law prohibits a nursing home from requesting or requiring that a family member or friend take on financial responsibility. A family member or friend should not sign such agreements as “responsible party.” A family member or friend can refuse to sign, or can modify the agreement to commit *only the resident’s funds* for payment, if the family member or friend has authority to commit the resident’s funds.

Requiring the Family Member or Friend to Handle Resident’s Affairs in a Certain Way

Family members and friends also should beware of admission agreements stating that the person signing the agreement 1) has access to the resident’s funds, 2) agrees to use the resident’s funds to pay for nursing home expenses, and 3) also agrees to take all necessary steps to seek Medicaid eligibility for the resident. If a resident ultimately owes money, nursing homes often sue the person who signed the admission agreement, arguing that the person failed to make payment from the resident’s funds and/or did not pursue Medicaid eligibility for the resident.

The viability of such lawsuits is questionable. Through the back door, they attempt to make the family member or friend responsible for nursing home expenses, and thus violate the Nursing Home Reform Law. Also, these lawsuits contradict the general legal rule that a representative is not responsible for the financial obligations of the person or business that is being represented.

That being said, courts sometimes have ruled for nursing homes in these cases, usually in situations where the family member or friend has cheated the resident by misusing the resident’s money. Just as frequently, however, the judge rules that the nursing home may have a claim against the resident but not against the family member or friend. This is particularly the case when the family member or friend has done their best.

HOW TO AVOID OR CHALLENGE PROVISIONS MAKING THE FAMILY MEMBER OR FRIEND FINANCIALLY RESPONSIBLE

During Admission

If a family member or friend is asked to agree to an improper provision, they should not hesitate to refuse, assuming that the resident already has moved into the nursing home. Once the resident has moved in, the nursing home has only six legitimate reasons for eviction (see “Eviction Without Proper Notice”), and refusal by a family member or friend to agree to an admission agreement provision is not one of those six reasons.

If the resident has not yet moved in, the situation is a bit more complicated. If the family member or friend objects to a certain provision, the nursing home possibly will refuse admission. In this situation, this guide recommends that the family member or friend consider refusing to sign, and explain politely but firmly that the agreement has an illegal and unenforceable provision. 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 committing the family member/friend to take any particular steps. Just delete the offending language and return the document to the nursing home staff.

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 some risk that the nursing home will refuse admission, but avoiding that risk generally is not worth signing an illegal and unfair

admission agreement. Also, refusing to sign is an important step in educating nursing home staff on the no-financial-guarantee rule.

[During or After Resident's Stay in Nursing Home](#)

What if the nursing home already is seeking payment from the family member or friend? The family member or friend should consult with a knowledgeable attorney about how the nursing home's demand can be countered. As discussed above, the law often is on the side of the family member/friend.

Problem #24: Forcing Residents to Arbitrate Disputes

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 DURING ADMISSION TO COMMIT TO ARBITRATION.

In an arbitration agreement, the parties agree that future disputes between them will not go to court, but instead will be handled by a private judge called an arbitrator. In nursing homes, the arbitration agreement generally is part of a much longer admission agreement. Sometimes the arbitration agreement applies to all disputes between the resident and the nursing home. Other times, depending on the arbitration agreement language, arbitration applies to claims made by the resident but not to claims made by the nursing home.

Arbitration generally is not a good choice for residents. Arbitration often is more expensive than court litigation, because the parties to the lawsuit must pay the arbitrator hundreds of dollars per 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, why should a resident commit to arbitration during 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 look like? 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 is known and the resident has consulted with a knowledgeable attorney.

Under the federal regulations, a nursing facility cannot require a resident or representative to sign an arbitration agreement. The arbitration agreement itself must state that arbitration cannot be required. Also, even if the resident or representative agrees to arbitration, they have 30 days in which to change their mind and rescind the arbitration agreement.²⁸

HOW TO AVOID OR CHALLENGE ARBITRATION AGREEMENTS

During Admission

A resident or resident's representative should not sign an arbitration agreement. The federal regulations are clear: a nursing facility cannot require a resident or representative to choose arbitration. In fact, under the regulations, the arbitration agreement itself must clearly inform the resident or representative that arbitration is optional.

Nonetheless, during the admissions process, a facility employee may push for the resident or representative to sign an arbitration agreement. If this happens, the resident or representative should point out that the arbitration agreement itself says that arbitration is optional. Or, if the agreement fails to include this language, the resident or representative should inform the facility employee that federal regulations prohibit a facility from requiring arbitration. This guide may be a good resource for showing that arbitration cannot be required.

Given the clear language of the federal regulations, most nursing homes will process admissions without a signed arbitration agreement. If, however, a nursing home denies admission based on the resident or representative refusing to sign an arbitration agreement, a complaint should be made to the state agency that inspects and licenses nursing homes.

Also, a resident or representative has options even after signing an arbitration agreement, because they can rescind that agreement within 30 calendar days. A simple signed statement is likely adequate: for example, "Under section 483.70(n)(3) of Title 42 of the Code of Federal Regulations, I rescind any arbitration agreement with [name of facility] signed on or about [date of arbitration agreement]." The resident should deliver the statement through a method that proves rescission took place within 30 days of the signing of the arbitration agreement. For example, a resident might send a notice through certified mail and through e-mail. The resident also should inform the relevant staff member in person, to emphasize that the resident is exercising their right under the federal regulations.

During or After Resident's Stay at Nursing Home, If Arbitration Agreement Previously Was Signed

Even if an arbitration agreement has been signed, and the 30-day rescission period has expired, all is not necessarily lost. 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. For one thing, the federal regulations set requirements about how an arbitration agreement is explained to a resident or representative, and how the resident or representative indicates their understanding of the agreement. Any conflict with the federal regulations may support a legal argument to invalidate the arbitration agreement. State law may give the resident or representative additional legal arguments, particularly if circumstances show that the nursing facility took advantage of the resident or representative.

To evaluate legal options, a resident or resident's representative should consult with a knowledgeable attorney.

Problem #25: Excessive Charges

WHAT YOU HEAR:

“YOU MUST PAY SEPARATELY FOR SERVICES LISTED ON THE NURSING HOME BILL.”

THE FACTS:

A NURSING HOME CAN BILL ONLY FOR CHARGES AUTHORIZED IN THE ADMISSION AGREEMENT.

Some nursing homes charge separately for various items and services—for example, catheter supplies, wound dressings, and diapers and other incontinence products. But these separate charges are generally improper and should not be paid.

If the resident’s care is covered by Medicare or Medicaid, the nursing home can charge the resident no more than the deductible or co-payment authorized by law, if any (see “A Brief Introduction to Medicare, Medicaid & Medicare Advantage,” page 6). There is only one exception to this rule. For certain non-health-care items—for example, cosmetics, televisions, plants, and “entertainment outside the scope of the activities program”—the nursing home can assess an additional charge if the resident requested the item after receiving written notice of the cost.²⁹

An additional federal regulation protects all residents, whether they pay solely out of pocket, or through Medicare, Medicaid, or another payor. This regulation requires that a nursing home notify residents of any extra charges “at the time of admission, and periodically during the resident’s stay.”³⁰ As a result, a nursing home cannot assess a charge unless the resident agreed in advance to pay that charge.

Finally, this same general rule—that a charge cannot be imposed without advance notice, and agreement—is part of standard contract law. Assume that a landlord advertised an apartment at \$1,500 monthly, but then billed the tenant extra for use of the stove or a balcony. The tenant certainly would object, and a nursing home resident likewise should object when presented with unauthorized extra charges.

HOW TO CHALLENGE EXTRA CHARGES

Assume that a resident is not eligible for Medicare or Medicaid payment, and the admission agreement lists a monthly rate of \$6,000, with no mention of additional charges. This month, however, the nursing home charges a total of \$6,211.50—the \$6,000 monthly rate plus \$211.50 for various items and services.

Assume also that a resident files a grievance (see page 9), but the nursing home refuses to budge. At that point, the resident has at least two choices. The more aggressive action 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 \$6,000 monthly. The nursing home likely will accept the \$6,000 grudgingly and will take no further action. If, however, the nursing home tries to evict for nonpayment, the resident can claim with justification that the bill already has been

paid in full. The resident likely will prevail in an eviction hearing although, of course, there can be no guarantees in any legal proceeding (see “Eviction Without Proper Notice” for discussion of evictions and eviction procedures).

The more cautious choice is to file a complaint with 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.

An advantage of the pay-only-what-is-owed strategy is that it gives the resident more control. If the resident pays only \$6,000, it is up to the nursing home to change the status quo. On the other hand, if the resident pays the \$6,000 plus the extra \$211.50, then the resident shoulders the burden of changing the nursing home’s practices.

Concluding Thoughts

These 25 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.

Endnotes

- 1 Sections 1395i-3 and 1396r of Title 42 of the United States Code. Sections 1395i-3 and 1396r are almost identical. Section 1395i-3 governs Medicare certification, while section 1396r governs Medicaid certification.
- 2 www.medicare.gov/care-compare/.
- 3 See Section 483.35 of Title 42 of the Code of Federal Regulations.
- 4 www.ltcombudsman.org.
- 5 Section 483.10(j)(1) of Title 42 of the Code of Federal Regulations.
- 6 Section 483.10(a)(2) of Title 42 of the Code of Federal Regulations (emphasis added).
- 7 See Section 483.21(b)(2)(ii) of Title 42 of the Code of Federal Regulations.
- 8 Section 483.10(f)(1) of Title 42 of the Code of Federal Regulations.
- 9 See Section 483.35 of Title 42 of the Code of Federal Regulations.
- 10 Section 483.10(e)(1) of Title 42 of the Code of Federal Regulations.
- 11 Sections 483.10(e)(1) and 483.45(e)(1) of Title 42 of the Code of Federal Regulations.
- 12 Section 483.15(c)(1) of Title 42 of the Code of Federal Regulations.
- 13 Section 483.15(c)(2)(i)(B) of Title 42 of the Code of Federal Regulations.
- 14 Section 483.10(j)(1) of Title 42 of the Code of Federal Regulations.
- 15 Surveyor's Guideline to Section 483.15(e)(1) of Title 42 of the Code of Federal Regulations, Appendix PP to CMS State Operations Manual.
- 16 Section 483.15(c)(1)(i)(E) of Title 42 of the Code of Federal Regulations.
- 17 Section 483.15(e)(1) of Title 42 of the Code of Federal Regulations.
- 18 Section 483.15(e)(1)(ii) of Title 42 of the Code of Federal Regulations.
- 19 Section 409.32(c) of Title 42 of the Code of Federal Regulations.
- 20 www.cms.gov/CEnter/Special-Topic/Jimmo-Center.html.
- 21 Guideline to Section 483.65(a) of Title 42 of the Code of Federal Regulations, Appendix PP to CMS State Operations Manual.
- 22 Section 483.10(e)(7) of Title 42 of the Code of Federal Regulations.
- 23 www.medicare.gov/care-compare/.
- 24 Section 483.10(f)(4) of Title 42 of the Code of Federal Regulations.
- 25 See Section 483.10(f)(4) of Title 42 of the Code of Federal Regulations.

26 See Section 483.10(f)(5) of Title 42 of the Code of Federal Regulations.

27 Section 483.15(a)(3) of Title 42 of the Code of Federal Regulations.

28 Section 483.70(n) of Title 42 of the Code of Federal Regulations.

29 Section 483.10(f)(11) of Title 42 of the Code of Federal Regulations.

30 Section 483.10(g)(17) of Title 42 of the Code of Federal Regulations.