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IMPORTANT NOTE

This nursing home guide is based on federal law and the law of California. It is intended for use by California residents, although some aspects (particularly those which are based on federal law) may be applicable in other states. If you are not a California resident, please consult a qualified attorney in your area to supplement and verify the information contained in this guide.

INTRODUCTION

Unfortunately, people typically know virtually nothing about nursing homes until the need arises. For example, how does one identify a good nursing home? How can expensive nursing home care payments be managed? How can a nursing home resident and his or her family ensure that the resident receives the best care possible?

This guide provides a good starting point in answering these and other significant questions. As a starting point, this guide should be used in conjunction with visits to nursing homes, discussions with representatives of the local Ombudsman Program, and, where necessary, consultations with a qualified attorney.

This guide is based on federal law and the law of California; if you reside in another state, much of this guide may not pertain to you. In addition, relevant law changes from year to year, so be sure you have the most recent edition of this guide. You should always consult local experts to supplement and verify the information

contained in the following pages.

This guide has been prepared by Eric Carlson and Janet Morris, attorneys of the Nursing Home Advocacy Project of Bet Tzedek Legal Services. Bet Tzedek (*The House of Justice*) is a non-profit public interest law center which provides free legal representation to low-income residents of Los Angeles County.

Bet Tzedek's Nursing Home Advocacy Project protects the legal rights of the residents of nursing homes and board and care homes. For example, attorneys of the Nursing Home Advocacy Project represent clients in court and make group presentations on topics related to long-term care.

If you or someone you know would benefit from these services, please contact Bet Tzedek at the telephone numbers listed below:

Los Angeles Office (including Nursing Home Advocacy Project): (323) 939-0506

San Fernando Valley Office: (818) 769-0136

FINDING A NURSING HOME

A search for a nursing home often occurs at a difficult time for a prospective resident and his or her family. They likely know little about nursing homes and, in fact, may be avoiding even the thought of a nursing home. In addition, the prospective resident may be in a hospital which intends to discharge him or her immediately.

Despite these factors, a prospective resident and his or her family should, whenever possible, make a careful search for the best available nursing home. Such a search may prevent innumerable future problems.

What type of living situations are possible?

Nursing Facilities

Nursing homes, convalescent homes, convalescent homes or sanitariums are different names for nursing facilities. Residents of nursing facilities often cannot walk and generally need help in performing at least one activity of daily living (feeding, dressing, toileting, bathing, etc.). They also may have substantial memory loss.

The staff of nursing facilities includes registered nurses and certified nursing assistants. Nursing facilities also must have easy access to doctors.

Some nursing facilities specifically provide care for residents with psychiatric

disorders. Other nursing facilities may offer specialized areas within the nursing facility, such as an Alzheimer's Disease unit.

Nursing facilities are licensed and inspected by the California Department of Health Services.

This guide uses the term "nursing home" to refer to a nursing facility.

Residential Care Facilities

A residential care facility, also called a board and care home, retirement home, rest home, or assisted living facility, provides its residents with a room, meals and activities. Residents usually must be able independently to perform most of their activities of daily living. A residential care facility is not required to have either nurses or doctors on staff, although medical services may be provided by a home health agency.

Residential care facilities are licensed and inspected by the California Department of Social Services.

Bet Tzedek publishes a consumer guide to the laws and practices of California's residential care facilities. An order form for that guide (entitled How to Get Care From a Residential Care Facility) is located on page 59 of this nursing home guide.

Remaining at Home

Various services may enable an elderly person to continue living in his or her

home, or in the home of a family member. For example, a visiting nurse can provide necessary health care. An aide can provide assistance with dressing, cooking and chores. In addition, an adult day care program can care for an elderly adult during the day, while the elderly adult's family members are at work.

The Medicare and Medi-Cal programs may assist in paying for home health care. The In-Home Supportive Services (IHSS) program may assist in paying for the work of an aide. Under certain circumstances, an IHSS payment can be made to an aide who is a family member of the elderly person.

How can a prospective resident, and/or his or her family, choose among nursing homes?

The following paragraphs discuss some relevant considerations.

Location

If possible, a resident's nursing home should be located near the resident's family members and friends. Nursing home residents with frequent visitors generally fare (physically and emotionally) better than residents without visitors.

(If a resident cannot live in a nursing home which is located near family mem-

bers and friends, a local church, synagogue, or senior center may be able to arrange friendly visits to the resident. In Los Angeles, for example, the Friends To the Elderly program ((310) 859-9336) pairs volunteers with nursing home residents who do not have family members or friends to visit them.)

Visiting to Determine Quality of Care

The prospective resident and his or her family members should visit each nursing home under consideration, and then carefully look, listen and smell. Are the residents up and dressed, and engaging in activities? Is the general atmosphere warm, pleasant and cheerful? Do residents look well groomed? Does the staff treat residents with respect?

The prospective resident and his or her family members should look at rehabilitation rooms. Some therapies require particular equipment.

The prospective resident and his or her family members should talk to current residents and their visitors. The residents and visitors should know better than anyone else the pluses and minuses of the nursing home.

The prospective resident and his or her family members should visit during meal-times. Are most residents in the dining room, rather than in their rooms? Is food delivered hot? Are residents promptly assisted if they need assistance in eating, or does food sit and cool on trays?

If possible, the prospective resident and his or her family members should visit a nursing home on a weekday, during a weekend and at night. The prospective resident and family members should assure that residents' needs are met during weekends and nights, when many nursing homes maintain a smaller staff.

Examining Official Records to Determine Quality of Care

The prospective resident and his or her family should examine the nursing home inspection records made by the California Department of Health Services. Each nursing home must make available a copy of its most recent inspection report.

In addition, each county's office of the Department of Health Services provides public access to the inspection records. Information about the availability of these inspection records can be obtained by calling the telephone numbers listed on pages 55-58 of this guide.

The inspection records summarize the findings of inspections conducted at each nursing home by the Department of Health Services. In addition, the inspection records note the issuance of any money penalties imposed in response to particularly blameworthy conditions.

Summaries of each nursing home's inspection records, along with other helpful information, are provided by the federal government on the Internet at <http://www.medicare.gov/>

[NHCompare/home.asp](http://www.nhcompare/home.asp). Similar summaries and information are provided by California Advocates for Nursing Home Reform at <http://www.canhr.org>.

Staff

The prospective resident and his or her family members should talk to the administrator, director of nursing, and social services director of each nursing home. The prospective resident and family members should ask the administrator and director of nursing to explain who at the nursing home is responsible for particular tasks, and how the nursing home knows that those tasks are completed. In particular, the administrator and director of nursing should explain who will report to family members or accept inquiries or complaints from those family members.

The prospective resident and his or her family members should ask the administrator or director of nursing how the nursing home provides rehabilitation therapy (physical, speech, occupational, respiratory, etc.). Therapists ideally will be available throughout the day for seven days weekly. The administrator and director of nursing should be asked for the therapists' qualifications and specializations, and whether or not the therapists work exclusively for one nursing home.

The prospective resident and his or her family members should examine the nursing home's activity schedule. The activity

schedule should contain varied activities, and should include activities for the evenings and weekends. The social services director should be asked if all activities are led by a member of the activities staff — if activities are the responsibility of the nursing staff or of volunteers, the activities are more likely to be canceled, due to a lack of time or preparation. The social services director also should be asked if a resident council and family council meet regularly. These councils are discussed on page 35 of this guide.

During all these discussions, the prospective resident and his or her family members should be conscious of staff members' attitudes. Do the staff members seem to recognize residents as individuals, and do the staff members actually accommodate residents' individual needs and preferences? Or do staff members routinely force all residents into the same schedule and the same activities?

Payment

Any prospective resident with relatively limited financial resources should assure that the nursing homes which he or she considers are certified to accept Medi-Cal reimbursement. Nursing homes not certified to receive Medi-Cal reimbursement may evict or transfer residents who, due to diminishing savings, become eligible for the Medi-Cal program after originally paying privately for nursing home care.

Admission Agreement

A prospective resident or his or her family members should examine and consider the admission agreement suggested by each nursing home. As discussed in this guide's chapter on admissions, state law requires a nursing home to make blank copies of its admission agreement available to the public at cost. As is also discussed in that same chapter, some nursing home admission agreements contain provisions harmful to residents and families.

Referrals by Professionals

A hospital discharge planner may offer valuable information, although prospective residents and their families should not automatically rely on a discharge planner's judgment. Some discharge planners may automatically refer patients to certain nursing homes simply for a hospital's convenience. Other discharge planners, in their rush to discharge a patient, may arrange for admission at whichever nursing home has an available bed.

Similarly, prospective residents and their families should not automatically rely on placement services or referral services. Some services, for example, may work solely from inadequate and out-of-date lists.

In addition, some services may receive money from nursing homes for each resident which the services place in those particular nursing homes. These services should be used with caution; they have

PAYING FOR NURSING HOME CARE

an incentive to place residents in nursing homes which will pay the services, even though those nursing homes may not provide good care.

(This discussion on the finding of a nursing home is based in part on Title 42 of the United States Code, sections 1395i-3(c)(1)(A)(ix), and 1396r(c)(1)(A)(ix) and (c)(8); and Title 42 of the Code of Federal Regulations, section 483.10(g).)

Nursing home care is expensive. Some nursing home residents have enough income or savings to pay privately for their care. The majority of California nursing home residents, however, rely at least in part on the Medi-Cal program and, to a lesser extent, on the Medicare program or private insurance policies.

How much does nursing home care cost?

Most California nursing homes charge between \$3,000 and \$5,000 monthly for care. Doctors' visits may create additional charges.

Do any government programs help a nursing home resident pay for his or her care?

Yes. Both the Medicare and Medi-Cal programs pay for nursing home care under some circumstances. Because of limiting rules, however, the Medicare program pays a small percentage of nursing home costs. By contrast, the Medi-Cal program pays almost one-half of California's total nursing home costs.

What's the difference between Medicare and Medi-Cal?

Under both the Medicare and Medi-Cal programs, a beneficiary must be at least 65 years old or disabled. Under Medicare, a beneficiary or a beneficiary's spouse must have made certain contributions (through payroll deductions) to the Social Security program. Under Medi-Cal, however, a beneficiary must have limited resources and income.

The Medicare program can be thought of as a health insurance policy purchased through premiums deducted from payroll checks. The Medi-Cal program, on the other hand, is a safety net medical program provided by the federal and state governments for persons who have little money to pay their medical bills.

In general, a person is eligible for Medicare if the person is at least 65 years old, and if the person or the person's spouse worked at least ten years in employment covered by Medicare.

Because Social Security eligibility also requires ten years of covered employment, eligibility for Medicare often is tied to eligibility for Social Security. Specifically, if a person is receiving Social Security retirement benefits, then the person and the person's spouse are each eligible for Medicare beginning on their respective 65th birthdays.

A person may be eligible for Medicare prior to his or her 65th birthday if he or she has developed serious medical problems. For example, a person of any age becomes eligible for Medicare after he or she has received Social Security disability benefits for at least two years. A person suffering from kidney failure becomes eligible for Medicare within three months, assuming that the person or the person's spouse has an adequate work history.

What's the difference between Medicare Part A and Medicare Part B?

Under certain conditions, Medicare Part A pays for a stay in a hospital or a nursing home, or pays for certain expenses of home health care. In addition, Medicare Part A pays for certain

expenses of hospice care provided to a terminally-ill person. Medicare Part A is commonly known as "hospital insurance."

By contrast, Medicare Part B is commonly known as "medical insurance." Medicare Part B pays for certain expenses of doctor services, therapies, tests, x-rays and medical equipment. Under some circumstances, Medicare Part B will pay for particular services provided in a nursing home or for home health care.

What medical services must a resident require before Medicare Part A will pay for nursing home care?

Medicare Part A pays nursing home charges only for residents who need "skilled nursing or skilled rehabilitation services." For example, "skilled" nursing services (as defined by the Medicare program) include intravenous feeding, the treatment of widespread skin disorders, and the monitoring of residents who require relatively sophisticated evaluations. "Skilled" rehabilitation services include, for example, "range of motion" exercises, services provided by a speech pathologist, and physical, occupational or speech therapy.

Note that a resident may qualify for Medicare Part A reimbursement if he or she requires only one "skilled" service.

Note also that the "skilled" services mentioned in the preceding paragraph are examples only. The Medicare regulations clearly state that a variety of conditions may qualify a resident for Medicare Part A payment of nursing home charges.

In regards to residents receiving therapy, nursing homes frequently - but falsely - claim that Medicare Part A cannot pay unless a resident's condition is improving. Actually, prescribed therapy can justify Medicare Part A reimbursement even without current progress, if progress can be reasonably expected in the foreseeable future, or if therapy is necessary to maintain a resident's condition.

It should be noted, however, that most long-term residents of nursing homes are not receiving "skilled" services as defined by the Medicare program. The Medicare regulations state that routine personal care services such as administration of medications, the maintenance of catheters, and the turning of residents do not qualify a resident for Medicare Part A payment of nursing home charges.

Who determines if a resident is receiving medical services which qualify the resident for Medicare Part A payment of nursing home charges?

The nursing home makes the initial decision on whether or not a resident is qualified medically for Medicare Part A payment of nursing home charges. Consequently, a resident or family member immediately and consistently should emphasize the "skilled" services which the resident requires.

If at any time (including the time of admission) the nursing home decides that the resident is not qualified for Medicare Part A payment of nursing home charges, the nursing home must give the resident written notice of the nursing home's decision. If the resident or family member feels that the resident is qualified medically for Medicare Part A payment of nursing home charges, and thus disagrees with the nursing home's decision, the resident or family member may appeal the nursing home's decision. The resident or family member begins the appeal by returning the written notice to the nursing home after checking a box which states: "I do want my bill for services I continue to receive to be submitted to the intermediary for a Medicare decision."

While the Medicare program considers an appeal of a nursing home's decision, the nursing home cannot bill the resident for the nursing home charges in dispute. If the Medicare program eventually agrees with the nursing home and concludes that the resident was not qualified medically for Medicare Part A payment of nursing home charges, the resident or

family member can appeal the Medicare program's decision as well. During this second appeal, however, the nursing home can bill the resident for the charges in dispute.

If a nursing home fails to provide a resident or the resident's family members with the required notice, a resident or family member should request in writing that the nursing home submit a bill to Medicare Part A, even if the resident's medical condition may not meet the requirements described earlier in this chapter. Under Medicare law, a nursing home's failure to give adequate notice may excuse the resident from paying the charges incurred during certain weeks or months, if the Medicare program finds that the resident could not have known that Medicare Part A would not be covering the charges incurred during that period of time.

Under what conditions will Medicare Part A pay for nursing home care?

As discussed above, Medicare Part A will pay for nursing home care only while a resident requires so-called "skilled" services. In addition, Medicare Part A may pay for nursing home care only if the resident enters a nursing home within 30 days after receiving at least three nights of hospitalization in an acute care hospital.

During the resident's first twenty days in the nursing home, Medicare Part A may pay all of his or her charges; during days 21 through 100 of the resident's nursing home care, however, Medicare Part A requires that the resident pay \$97.00 daily before Medicare Part A can pay the remainder of the nursing home charges. (This daily amount of \$97.00 is effective January 1, 2000, and will increase slightly in the beginning of subsequent years.)

Medicare payment never continues indefinitely. The Medicare program cannot pay for nursing home care for more than 100 days per benefit period. A new benefit period starts when the resident has not received Medicare reimbursement for either a hospital stay or a nursing home stay within the previous 60 days.

As a result of the limitations discussed in the preceding paragraphs, the Medicare program pays a small percentage of California nursing home charges. In summary, Medicare does not pay for the routine care which most residents need. In addition, Medicare may pay completely only for the first twenty days of a resident's stay and only when that stay follows a hospitalization of at least three nights.

Will a Medi-Gap insurance policy increase a resident's nursing home benefits under Medicare Part A?

Yes, but in a relatively limited way.

A Medi-Gap policy (also known as a Medicare supplemental policy) is issued by a private insurer. Such a policy pays Medicare deductibles and co-payments, but does not expand the services covered by Medicare Part A. Thus, in Part A coverage of nursing home care, the only benefit of a Medi-Gap insurance policy is the payment of the \$97.00 daily co-payment, if the resident qualifies for Medicare coverage for any day during days 21 through 100 of the resident's nursing home stay.

Is a "Medicare room" reserved exclusively for those residents whose nursing home care is covered by the Medicare program?

No. A Medicare room (or bed or "distinct part") is certified for Medicare Part A reimbursement. Medicare certification allows a nursing home to bill the Medicare program for certain stays in a Medicare room, but does not prohibit a nursing home from using a Medicare room for residents who pay privately or through the Medi-Cal program.

What is a Medicare HMO?

"HMO" is an abbreviation for health maintenance organization. An HMO provides health care in return for a set monthly fee. An HMO generally requires an enrollee to receive all of his or her health care from the HMO.

A Medicare HMO provides health care to Medicare beneficiaries who have signed over their Medicare benefits to the HMO. Once a beneficiary signs over the Medicare benefits, the Medicare program each month pays a certain set rate to the HMO, and the beneficiary receives his or her health care from the HMO.

What nursing home care is covered by a Medicare HMO?

By law, a Medicare HMO must provide a Medicare beneficiary with at least the services and items which Medicare would have provided for him or her. Therefore, a Medicare HMO must cover at least 100 days of nursing home care for an enrollee who needs "skilled" nursing home care, as defined by Medicare law.

In order to attract enrollees, most Medicare HMOs eliminate the \$97.00 daily co-payment for days 21 through 100 of nursing home care. Some Medicare HMOs increase coverage to 150 days of “skilled” nursing home care.

In some instances this expanded coverage is a mirage, due to the fact that many Medicare HMOs refuse to authorize the promised nursing home care. Although on paper an enrollee may be entitled to 150 days of nursing home care, the HMO may stop payment after a few days, claiming that the resident no longer needs “skilled” nursing home care.

Can a resident appeal a Medicare HMO’s refusal to pay for nursing home care?

Yes. When a Medicare HMO denies or terminates nursing home coverage, the HMO must give a written notice listing the specific reasons for the HMO’s refusal to pay, a notification of the right to request an “expedited appeal,” and an explanation of the procedures to be followed in requesting an expedited appeal.

A resident always should request an expedited appeal of a denial or termination, even if the HMO failed to give proper notice. The request should be made to the HMO’s member services department, or to another department designated by the particular HMO. The request should be made first over the tele-

phone, then in a confirming letter.

Who rules on an appeal of a Medicare HMO’s refusal to pay for nursing home care?

Initially the HMO itself rules on the appeal. If, after the HMO’s ruling, the resident still is dissatisfied, he or she may pursue a further appeal to the Center for Health Dispute Resolution, a private firm under contract to the federal Health Care Financing Administration.

How long does it take to get a decision in an appeal of a Medicare HMO’s refusal to pay for nursing home care?

The answer varies depending on whether the appeal is handled on an expedited basis.

If an appeal is handled on an expedited basis, the HMO must make a decision within 72 hours after receiving the request for an appeal. An extension of up to ten days is possible if the HMO

decides both that it needs more information, and that the delay is in the resident's best interests.

An appeal must be handled on an expedited basis only if a delay could jeopardize the resident's life, health, or ability to function. If a doctor requests an expedited appeal, the appeal must be handled on an expedited basis. Otherwise, the HMO decides whether an expedited appeal is necessary.

If an appeal is not handled on an expedited basis, or if the appeal is referred to the Center for Health Dispute Resolution after an unfavorable decision by the HMO, the appeal process may take weeks or months.

Can a nursing home require payment while the resident is appealing a denial by a Medicare HMO?

Yes. If the resident is eligible for the Medi-Cal Program, the Medi-Cal Program will pay for nursing home care. Otherwise the resident most likely will have to pay for nursing home care while the appeal is being considered.

After signing his or Medicare benefits over to a Medicare HMO, may an enrollee later

switch back to Medicare benefits?

Yes. An HMO enrollee may return to the Medicare program by submitting a written request for disenrollment to either the HMO or the local Social Security office. The disenrollment generally will become effective on the first day of the next month.

When will Medi-Cal pay for an unmarried resident's nursing home care?

An unmarried person is eligible for Medi-Cal benefits if he or she is at least 65 years old or disabled, and has less than \$2,000 in available resources. (Availability of resources is discussed below; a home generally is considered unavailable.) In contrast to the Medicare program, the Medi-Cal program does not have restrictive medical requirements for the coverage of nursing home care. Under Medi-Cal, if a financially-eligible individual needs nursing home care, the Medi-Cal program will pay for that care.

Under the Medi-Cal program, an unmarried nursing home resident is allowed to keep \$35 of his or her monthly income as a personal allowance. He or she must apply any additional income

(the Medi-Cal "share of cost") to nursing home charges and to certain current and past medical bills. The Medi-Cal program then will pay the remainder of the nursing home charges.

When will Medi-Cal pay for a married resident's nursing home care?

As is described in the preceding paragraphs, the Medi-Cal program generally does not pay for nursing home care until a nursing home resident has spent virtually all of his or her available resources. As a result, in past years a spouse of a nursing home resident had been forced to spend virtually all of the couple's resources for nursing home care. In response to this situation, federal and state governments decided that the Medi-Cal program should allow a spouse of a nursing home resident to retain additional resources and income (assuming the spouse does not also live in a nursing home).

Consequently, a couple comprised of a nursing home resident and an "at-home" spouse is eligible for Medi-Cal payment of the nursing home charges if the couple does not have over \$86,120 in available resources. From the couple's joint income, the at-home spouse is allowed to keep a monthly income of at least his or her individual monthly income or \$2,103, which-

ever is greater. (The resource and income amounts quoted in this paragraph are effective January 1, 2000, and will be increased slightly at the beginning of subsequent years.) Of the couple's remaining income, \$35 is given to the resident as a personal allowance and the remainder is applied to nursing home charges and to certain current and past medical bills. The Medi-Cal program then will pay the remainder of the nursing home charges.

Under certain circumstances, an at-home spouse can obtain an order from a court or an administrative law judge which will allow the at-home spouse to retain additional resources or income. Such an order can allow the couple to retain more than \$86,120 in available resources, if the income which could be generated by the retained resources would not cause the total monthly income available to the at-home spouse to exceed \$2,103. Such an order can also allow the at-home spouse to retain more than \$2,103 in monthly income, if the extra income is necessary "due to exceptional circumstances resulting in significant financial duress."

Once the Medi-Cal eligibility of a married resident is established, the couple must allocate their resources between themselves so that no more than \$2,000 in available resources is held in the resident's name. Once this allocation is completed, the resident will remain eligible for Medi-Cal as long as his or her available resources do not exceed \$2,000, regardless of the amount of his or her spouse's available resources.

Examples of Eligibility Calculations for a Married Couple

Assume that Mr. Jackson just moved into a nursing home, although his wife lives in the couple's home. The Jacksons have savings of \$50,000 in a bank account. Mr. Jackson receives a \$1,200 monthly payment from the Social Security Administration, and Mrs. Jackson receives a \$1,000 monthly pension.

RESOURCES

The Jacksons' home is considered an unavailable resource, since Mrs. Jackson lives there. The Jackson's available resources thus total \$50,000, which is less than the limit of \$86,120. Mr. Jackson is eligible for Medi-Cal payment of his nursing home care.

INCOME

The Jacksons' joint income totals \$2,200. Mrs. Jackson is entitled to an allowance of \$2,103 monthly, and Mr. Jackson is entitled to his allowance of \$35. The couple thus is entitled to a joint allowance of \$2,138 (\$2,103 + \$35); each month Mr. Jackson must pay the nursing home a share of cost of \$62 (\$2,200 - \$2,138).

INCREASED RESOURCE ALLOWANCE

Now modify the example. Assume that the Jacksons have savings of \$100,000, Mr. Jackson receives a monthly Social Security payment of \$700, and Mrs. Jackson receives a monthly pension of \$300.

At first glance, Mr. Jackson seems to be ineligible for Medi-Cal, because the couple's joint savings of \$100,000 exceed the resource limit of \$86,120. But, because the Jacksons' joint income including interest income is less than the couple's total income allowance, the Jacksons will be allowed to retain all of their savings.

Assume a 6% simple interest rate on the Jacksons' savings. Their savings account produces \$6,000 in interest each year, or \$500 monthly. Thus the Jackson's monthly income totals \$1,500 — Mr. Jackson's \$700 payment plus Mrs. Jackson's \$300 pension plus the \$500 interest.

Because the Jacksons' total monthly income is less than the \$2,138 total income allowance for the couple (\$2,103 for Mrs. Jackson, plus \$35 for Mr. Jackson), the Jacksons will be able to obtain an order which will increase their resource allowance to a total of \$100,000.

What resources are considered

unavailable by the Medi-Cal program?

As described in the preceding paragraphs, the Medi-Cal program covers only persons or couples with limited resources. Resources include money, bank accounts, real estate, investments, insurance policies, and other items.

The Medi-Cal program, however, considers many resources unavailable and will not count those resources against the applicable resource limit. For example, as discussed below, the value of a house used as a residence is considered unavailable. Similarly considered unavailable is the value of household goods, a necessary automobile, term life insurance, burial plots, or irrevocable burial plans.

Property used in a business is considered unavailable. Rental property does not qualify as business property.

The cash surrender value of a whole life insurance policy is considered unavailable only if its face value is no more than \$1,500. Similarly considered unavailable is a revocable burial plan of no more than \$1,500.

Work-related pensions and retirement accounts (IRAs, for example) automatically are considered unavailable if owned in the name of the resident's spouse. If such pensions and retirement accounts are owned in the resident's name, they are considered unavailable only if payment actually cannot be made from the pension

or account at the present time, or if periodic payments of principal and interest are being made to the resident from the pension or account. If periodic payments are being made, the payments are considered income and accordingly are considered in the calculation of the resident's share of cost.

An annuity may be considered unavailable under certain circumstances. On the other hand, resources held in trust for a nursing home resident generally will be considered available to that resident. A detailed discussion of these issues is beyond the scope of this guide; contact a knowledgeable attorney for advice.

Does a nursing home resident have to sell his or her home in order to qualify for Medi-Cal?

Absolutely not. Under virtually all circumstances, a resident's home (his or her principal residence) is considered an unavailable resource and is not counted against the Medi-Cal resource limitations.

Specifically, a home is an unavailable resource simply if the resident intends to return to his or her home. The Medi-Cal application asks the resident if he or she intends to return to his or her home; if that question is answered "yes," the Medi-Cal program will not count the value of the home against the resource limitation, even if the resident medically has no realistic chance of returning to his or her home.

The relevant question on the Medi-Cal

application could be paraphrased as follows: "If the resident were completely healthy, would the resident live in his or her home?" If the answer to this paraphrased question is "yes," the answer on the Medi-Cal application should also be "yes."

In addition, the home is considered an unavailable resource if the resident's spouse or dependent relative lives in the home. Similarly, the home is an unavailable resource if the resident's child, brother or sister 1) lives in the home and 2) began living in the home at least one year before the resident entered the nursing home.

Regardless of the preceding discussion, nursing home residents and their families are often told to sell the resident's home in order to pay for nursing home care. This is particularly bad advice: such a sale converts an unavailable resource (the home) into an available resource (cash) which likely will make the resident ineligible for Medi-Cal for some time.

Are the entire contents of a joint account considered available by the Medi-Cal program?

In general, yes. The entire contents of a joint account are presumed to be available to a nursing home resident, unless he or she clearly can trace all or part of the joint account to income or transfers of the other person listed on the joint account.

Will the Medi-Cal program consider certain resources unavailable if an insurance policy has paid for part of a resident's nursing home care?

Yes, under limited circumstances. Under the California Partnership for Long-Term Care, the Medi-Cal program will consider an amount of resources unavailable if an insurance policy certified by the Medi-Cal program has paid at least that amount to a nursing home on the resident's behalf.

Can a resident give away resources in order to become eligible for Medi-Cal?

In general, a resident's giving away of resources causes the resident to be ineligible for Medi-Cal reimbursement from the month of the give-away for the amount of time those resources could have paid for nursing home care. (For this calculation, the Medi-Cal program assumes as of 2000 that nursing home care costs \$3,836 monthly.) Any transfer of resources for which the resident received adequate compensation is considered a sale, not a give-away, and does not result in Medi-

Cal ineligibility.

This general rule has multiple exceptions. For example, a give-away of resources to a resident's spouse or disabled child will not create Medi-Cal ineligibility. Transfer of any resource considered unavailable by the Medi-Cal program also will not create ineligibility. In addition, the Medi-Cal program will not penalize a resident for a give-away which occurred more than 30 months before the month of the Medi-Cal application.

The relevant law is complicated — even more complicated than this short answer suggests. No one should make an eligibility-accelerating give-away without first consulting with a knowledgeable attorney.

Can the Medi-Cal program impose a lien on a resident's home during the resident's lifetime?

In general, no. The Medi-Cal program can assess a lien only if 1) the resident has stated that he or she does not intend to return to his or her home, and 2) the resident has listed the home for sale, but it has not yet been sold.

The law pertaining to Medi-Cal estate claims is complicated, and changes frequently. Specific questions should be

directed to a knowledgeable attorney.

After a resident's death, can the Medi-Cal program take money from the resident's estate in order to repay the Medi-Cal program for benefits paid on behalf of the resident?

Yes, in general. The Medi-Cal program, however, cannot make a claim against the resident's estate if the resident is survived by a spouse, a minor child, or a child who is disabled under the standards of the Social Security Administration. In addition, under the recent provisions of the California Partnership for Long-Term Care, the Medi-Cal program cannot make a claim against a certain amount of a resident's estate if an insurance policy certified by the Medi-Cal program paid at least that amount to a nursing home on the resident's behalf. Furthermore, the Medi-Cal program must waive an estate claim if the resident's heirs show that enforcement of the claim would cause them to suffer a substantial hardship.

The law pertaining to Medi-Cal estate claims is complicated, and changes frequently. Specific questions should be directed to a knowledgeable attorney.

Can a nursing home impose

charges on top of the nursing home's daily rate?

Some nursing homes impose separate charges for various services or items (therapy sessions, catheter supplies, towels, etc.). These charges are improper unless the resident in the admission agreement agreed to pay a specific extra amount for the particular service or item.

In addition, if a resident is eligible for the Medicare or Medi-Cal program, a nursing home cannot bill separately for services or items covered by the program. The coverage of either program is extremely broad. For example, the Medi-Cal program's basic daily rate covers payment for room and board (including laundry services) and all routine nursing services (including diapers, when necessary). The Medi-Cal program also covers a limited number of doctor's visits, prescriptions, eyeglasses, hearing aids, prosthetic devices, and ambulance trips. The Medi-Cal program does not cover beauty shop services, although routine shampooing, haircutting, and fingernail and toenail clipping are included as part of routine nursing services.

Can a nursing home force a resident to use a particular pharmacy?

No. A nursing home cannot force a resident to purchase medication, medical supplies or medical equipment from any particular source.

Are insurance policies covering nursing home care a good investment?

There is no universal answer to this question. A person can answer this question only by examining policies and considering his or her age, health and financial situation.

In general, someone should not purchase nursing home care insurance if he or she is eligible or soon will become eligible for Medi-Cal reimbursement. Any policy chosen should limit premium increases. In addition, any policy chosen should contain a provision that will increase benefit

levels if (as is likely) the cost of nursing home care increases.

Under California law, policies covering nursing home care cannot require that a resident be hospitalized before he or she is admitted to a nursing home. These policies cannot claim to cover only “skilled” nursing home care. Furthermore, these policies cannot specifically deny coverage to residents suffering from Alzheimer’s Disease or another degenerative brain disorder, unless the denial is based on the resident’s failure to disclose a degenerative brain disorder to the insurance company when applying for the policy.

California law provides that any insurance policy for nursing home care can be cancelled with a full refund if the cancellation is requested within 30 days of the policy’s delivery.

Under certain conditions, an insurance policy for nursing home care enables a resident more quickly to become eligible for the Medi-Cal program. As is discussed earlier in this chapter, this acceleration of Medi-Cal eligibility occurs only

ADMISSION TO A NURSING HOME

with an insurance policy which has been certified by the Medi-Cal program under the provisions of the California Partnership for Long-Term Care.

(This discussion on the payment of nursing home expenses is based primarily on Title 42 of the United States Code, sections 426, 1395c, 1395d, 1395f, 1395k, 1396, 1396p, and 1396r-5; Title 42 of the Code of Federal Regulations, sections 409.30 through 409.36, 409.60, 417.608, and 417.617; the California Health and Safety Code, sections 1320 and 1599.67(a); the California Insurance Code, sections 10231 through 10237.3; the California Welfare and Institutions Code, sections 11158, 14006, 14006.7, 14009.5, 14110.4, 14134.6, and 22000 through 22013; Title 22 of the California Code of Regulations, sections 50201, 50203, 50420, 50425, 50453, 50453.7, 50461, 50467, 50475 through 50479, 50605, 51123, 51511, 58003, and 58009; the California Department of Health Services All-County Letters 86-33, 89-54, 90-01, 90-03, 90-11, 91-28, 95-22, 95-48, 95-65, 96-11, 96-44, 97-47, 99-59 and 00-07; the California Department of Health Services District Administrator Memorandum PTB 92-11; Johnson v. Rank (N. D. Cal. 1989); Hunt v. Kizer (E. D. Cal. 1989); Sarrassat v. Sullivan (N.D. Cal. 1989); Medicare Skilled Nursing Facility Manual, sections 357 and 358; Commerce Clearing House Medicare and Medicaid Guide, sections 1309 and 13010; and letter from Frank Martucci, Medi-Cal Program, to Pat McGinnis, California Advocates for Nursing Home Reform, March 23, 1990.)

Nursing home admissions often occur during stressful times for a resident and family. As a result, the resident and his

or her family members are inclined to agree to whatever conditions the nursing home presents. This inclination should be resisted. Some nursing homes request illegal or unfair conditions that, if accepted, will come back to haunt the resident and family.

Can a nursing home designate certain beds as “Medi-Cal beds”?

No. If a nursing home is certified to participate in the Medi-Cal program, a resident eligible for Medi-Cal can reside in any bed in the nursing home.

Can a nursing home require that a resident pay the private pay rate for a certain period of time?

A nursing home cannot require that a resident certify that he or she is not eligible for Medi-Cal or Medicare nursing home benefits. Similarly, a nursing home cannot require that a resident promise that he or she will not become eligible for

those benefits in the future.

Sometimes a nursing home will request that a resident agree to pay the private pay rate for a certain period of time. These “duration of stay” agreements are illegal for the reasons discussed in the preceding paragraph.

At the present time, nursing homes are allowed to ask a resident for information on his or her income and savings. Nonetheless, under certain circumstances this practice could be challenged by characterizing it as a nursing home’s roundabout way of assuring that a resident will not become eligible for Medi-Cal in the future.

Can a nursing home require that a resident post a deposit as a condition of admission?

A nursing home cannot require a deposit from a resident if either the Medi-Cal program or the Medicare program makes payments for the resident’s stay in the nursing home. A nursing home, however, may require a deposit from a resident who pays for his or her stay in the nursing home without assistance from the Medi-Cal and Medicare programs.

Can a nursing home require that a resident’s family member or friend become per-

sonally liable for the nursing home’s bills?

No. Federal law prohibits a nursing home from requiring a third party guarantee of payment as a condition of a resident’s admission. Thus a resident’s family member or friend cannot be required to guarantee the resident’s payments to a nursing home.

Many nursing homes, however, use admission agreements which evade the spirit and (arguably) the letter of the federal law. These admission agreements correctly state that a guarantor cannot be required, but then claim that any person voluntarily can agree to become a “[financially] responsible party,” in other words a guarantor.

No person should agree to become a financially responsible party for a resident’s nursing home bills. Such an agreement cannot be required and legally can offer no benefit to a resident. Consequently, a resident’s family members and friends should beware of signature lines entitled “Responsible Party”; oftentimes these signature lines do not define the term “responsible party” but implicitly refer to an earlier paragraph which defines a responsible party as a person financially liable for nursing home charges.

Furthermore, a person who has signed

as a financially responsible party should not assume that he or she is financially responsible for all nursing home bills. Such a voluntary promise to pay is unenforceable, because the nursing home promises nothing in return for the financial guarantee. In addition, any voluntary guarantee is unenforceable because it is grossly unfair (or unconscionable, in legal terms).

This guide's analysis of nursing home guarantees is supported by Podolsky v. First Healthcare Corporation, a 1996 opinion of the California Court of Appeal.

Can a nursing home require a resident's authorized representative to agree to apply the resident's money to nursing home charges?

Yes. Notwithstanding the preceding discussion, a nursing home may require

a resident's authorized representative (a conservator, a Medi-Cal representative, a representative payee for Social Security benefits, etc.) to agree to apply the resident's money to nursing home charges. As discussed above, a resident's authorized representative cannot be required to guarantee payment with the representative's money.

QUALITY OF CARE

Can a nursing home require during the admission process that a resident consent to all medical treatment?

No. Admission agreements can solicit consent only for routine nursing care or emergency care.

How can a resident and family recognize problems in an admission agreement before the agreement is to be signed?

State law requires nursing homes to make blank copies of their admission agreements available to the public at cost. Before making an admission decision, a resident or family considering a particular nursing home should obtain a copy of that nursing home's admission agreement.

(This discussion on admissions is based primarily on Title 42 of the United States Code, sections 1395i-3(c)(5) and 1396r(c)(5); Medicare Skilled Nursing Facility Manual, section 317; the California Health and Safety Code, sections 1599.63, 1599.70, and 1599.72; Title 22 of the California Code of Regulations, section 72528(g); and *Podolsky v. First Healthcare Corporation*, 50 Cal. App. 4th 632, 58 Cal. Rptr. 2d 89 (1996)).

A nursing home's quality of care depends upon a whole host of factors. For example, the care received by a nursing home resident obviously depends in part on the qualifications of the staff and the sophistication of the equipment. In addition, the resident's care depends on less measurable considerations, such as the diligence of the staff and the general atmosphere of the nursing home.

State and federal law and regulations attempt to assure adequate care by requiring nursing homes to meet certain minimum standards. Some of these standards rely on certain tangible requirements. Other standards define adequate care by referring to intangible actions or outcomes (e.g., "highest practicable... well-being").

Residents and family members should be prepared to improve a nursing home's quality of care by insisting upon the nursing home's compliance with relevant laws and regulations. Too frequently, residents and family members defer to a nursing home on questions concerning quality of care, assuming that laypersons shouldn't dabble in medical issues.

Residents and family members actually are well able to determine the resident's care. Many issues relating to quality of care involve little technical information; a nursing home generally falls short not because it makes a bad treatment decision, but because its employees fail to perform neces-

sary tasks. Informed pressure applied by residents and family members can cause a nursing home to hire more staff persons or to demand better performance from the existing staff.

Must a nursing home help a resident to improve his or her condition?

Yes. Federal law applicable to most nursing homes requires that a nursing home “provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.” In general, this phrase means that a resident’s condition should not decline in a nursing home unless the resident’s condition makes such a decline inevitable. As the term “nursing home” implies, the nursing home is expected to nurse and rehabilitate the resident to improved health.

How is a resident’s nursing home care planned?

The resident’s care is based on a written care plan, which must include the resident’s choices regarding treatment and daily activities.

Specifically, a care plan “is initially

prepared, with the participation to the extent practicable of the resident or the resident’s family or legal representative, by a team which includes the resident’s attending physician and a registered professional nurse with responsibility for the resident.” The care plan must describe “the medical, nursing, and psychosocial needs of the resident and how such needs will be met.”

A care plan is based in part on a written assessment of the resident’s condition, abilities and limitations. A nursing home must conduct this assessment soon after a resident’s admission, and must revise the assessment after significant changes in the resident’s condition or at least every three months. The assessment must be conducted or coordinated by a registered professional nurse.

Unfortunately, the care plan process sometimes is treated as an unimportant formality. For example, a nursing home may write the same vague care plan for virtually all of its residents. Or a resident’s family member may skip the care plan meetings scheduled by the nursing home. This attitude — whether held by the nursing home or the resident’s family — can have devastating effects on the resident. If a resident’s care plan becomes a meaningless piece of paper, then the resident may receive nothing more than meals and supervision.

Residents and their family members should emphasize the care plan. Through a care plan, a resident and his or her family members can make sure that the resident’s wishes are observed. In addition, if prob-

lems develop, the resident or family member can force the nursing home to provide the treatment and services listed in the care plan.

What must a nursing home do to assure that a resident's simple, daily necessities are completed?

Under federal law, a nursing home is expected to help a resident to maintain or improve his or her ability to bathe, dress, groom, walk, eat, talk, and use the toilet. If a resident is unable to perform any of these activities of daily living, the nursing home is required to assist the resident accordingly. State law specifically requires that a nursing home provide the bathing, shampooing, teethbrushing, shaving, and cutting of toenails and fingernails required by the resident. A resident requiring help in eating must be provided with assistance or, if appropriate, with special equipment to enable independent eating.

In providing assistance, a nursing home must help a resident remain as independent as possible. Assume, for example, that a resident can feed himself if he is helped by a nursing assistant, but the nursing home could save time and money by either having the nursing assistant feed the resident, or by having a stomach tube inserted into the resident. In this situa-

tion, the nursing home must direct the nursing assistant to help the resident feed himself. By doing so, the nursing home maintains the resident's independence as much as is possible.

What must a nursing home do to maintain a resident's ability to move his or her limbs?

Under federal law, a resident without limitations in how he or she moves should "not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable." A resident with a limited range of motion must receive "appropriate treatment and services to increase range of motion to prevent further decrease in range of motion." Restraints (either physical restraints or certain medications) are not to be applied unless unavoidable; this question is discussed in some detail in this guide's chapter on residents' rights.

What rehabilitation services and activities must a nursing home provide?

Consistent with the above require-

ments, federal law requires that a nursing home provide rehabilitative services for the improvement or maintenance of a resident's condition. These rehabilitative services include (but are not limited to) physical therapy, occupational therapy, and speech therapy. Significantly, a rehabilitative service must be provided to any resident for whom the service has been prescribed, including a resident who receives financial assistance from the Medi-Cal program.

A nursing home also must provide activities for its residents. An activity program must follow a written, planned schedule. In addition, each resident must have an individualized activity plan which is consistent with the resident's other treatment.

What must a nursing home do to prevent or treat pressure sores?

Again, a nursing home must prevent a resident's decline as much as is possible. A resident without pressure sores should not develop them "unless the [resident's] clinical condition demonstrates that they were unavoidable"; among other actions, a nursing home must turn or shift residents who otherwise would be immobile in a bed or wheelchair. In addition, a resident with pressure sores must receive treatment to heal the sores and prevent infection. A nursing home must notify a physician

when a pressure sore develops and when treatment of such a sore is not effective; this notification must be documented in the resident's record.

How must a nursing home help a resident control his or her urine?

A resident without adequate control of his or her bladder must receive treatment to restore normal bladder functioning as much as possible. Specifically, if a resident needs assistance in order to go to a bathroom, or to use a toilet or bedpan, then the nursing home must provide that assistance. A resident should not be given a catheter or diaper unless it is a necessity, even if the nursing home could save time and money by using the catheter or diaper.

If a resident does have a catheter, the nursing home must monitor the resident's fluid intake and output. The nursing home must provide treatment to prevent urinary tract infections.

Can a nursing home provide a reduced level of care and services to a resident who receives financial assistance from the Medi-Cal program?

No. The laws explained in this chapter apply to all residents, regardless of a particular resident's form of payment. Specifically, a nursing home is not allowed to discriminate against a resident who is eligible for the Medi-Cal program.

How is a doctor involved in a resident's care?

A nursing home must assure that each resident's care is supervised by a doctor selected by the resident or by the resident's authorized representative. The nursing home also must assure that an alternate doctor is available, in case of an emergency. The attending doctor generally must visit and evaluate the resident when medically appropriate, and at least once every 30 days.

The nursing home must keep the attending doctor informed of a resident's condition. For example, the nursing home must notify the doctor of a sudden or marked change in a resident's condition or of a resident's five pound change in weight during a 30-day period.

How must a nursing home serve meals?

A nursing home must provide residents with at least three meals each day. Dinner during the evening and breakfast the following morning cannot be separated by more than fourteen hours. The nursing home must follow resident food preferences as much as possible, making substitutions from appropriate food groups.

Is a resident absolutely obligated to follow the same schedule as every other resident?

No. When organizing residents' schedules, a nursing home must make "reasonable accommodations" to order to meet residents' individual needs and preferences. For example, if a resident prefers to sleep until 8:00 a.m., the nursing home should not wake the resident at 6:30 a.m. The nursing home can comply with the law by waking the resident at 8:00 a.m., and by having cereal, fruit and juice available for residents who get up after the standard breakfast time.

If a nursing home does not have enough staff members to

TRANSFERS AND DISCHARGES

provide required services, is the nursing home excused from the laws discussed in this chapter?

No. In many instances, a nursing home will claim that it does not have enough employees to provide the individualized care required by law. When confronted with this argument, a resident or family member should insist that the nursing home comply with legal requirements, and can suggest that the nursing home hire and schedule an adequate number of employees.

Must a nursing home allow a resident to see the resident's medical records?

Yes. If a resident or resident's representative requests to see the resident's medical records, the nursing home must make those records available within 24 hours, not including weekends and holidays. The nursing home must provide copies of the medical records within two working days after a request for copies. The nursing home can charge no more than 25 cents per page for copies.

(This discussion on quality of care is based pri-

marily on Title 42 of the United States Code, sections 1395i-3(b) and 1396r(b); Title 42 of the Code of Federal Regulations, sections 483.10, 483.15, 483.20, 483.25, and 483.45; the California Welfare and Institutions Code, section 14124.10; the California Health and Safety Code, section 123110; and Title 22 of the California Code of Regulations, sections 72303, 72307, 72311, 72315, 72335, and 72379 through 72389.)

When can a nursing home transfer or discharge a resident?

Nursing home residents, like tenants in an apartment building, generally have the right to stay where they are living. A nursing home resident can only be involuntarily transferred or discharged under one of five circumstances:

1) The nursing home cannot meet the resident's needs, and as a result the resident's welfare requires a transfer or discharge.

2) The resident's health has improved so that he or she no longer needs the services of a nursing home.

3) The resident's presence in the nursing home endangers the health or safety of other residents.

4) The resident has failed to pay for his or her stay at the nursing home, despite having received reasonable and appropriate notice of nonpayment.

5) The nursing home is ceasing operations.

Other than these five circumstances, a nursing home generally is not allowed to transfer or discharge a resident against his or her will.

Sometimes nursing homes justify transfers or discharges with various improper reasons — for example, a resident's change in payment source, a decision by the Medi-Cal program to deny payment for nursing home care, a resident's demands for help from nursing staff, etc. None of these scenarios, however, automatically justifies transfer or discharge.

Does a denial of payment by the Medicare program or an HMO automatically justify the transfer or discharge of a resident?

No. Such denials are not among the five reasons specified in the preceding section. In addition, a denial by the Medicare program or an HMO is not equivalent to nonpayment: such a denial does not prevent the nursing home from receiving

payments from the resident, the Medi-Cal program, or another source.

Do transfer and discharge laws apply to nursing homes which generally provide short-term care?

Yes. The transfer and discharge laws apply to all nursing homes which are certified to accept payment from the Medicare and/or Medi-Cal programs. The average length of stay of a resident is irrelevant; for example, a hospital's transitional care unit (which is licensed as a nursing home) must follow the transfer and discharge laws outlined in this chapter.

What notice of transfer or discharge must a nursing home give?

A nursing home must give a resident and family adequate notice of any transfer or discharge. The nursing home's notice of a transfer or discharge generally must be given to the resident and family at least thirty days before the transfer or discharge. Under some circumstances, notice of a transfer or discharge requires only "practicable" advance notification.

Notice of a transfer or discharge must

be written and must specify the reason for the transfer or discharge. In addition, the notice must inform the resident and family that they can appeal the nursing home's decision to the California Department of Health Services. Accordingly, the notice must list the telephone numbers and addresses for the local offices of the Department of Health Services and the Ombudsman Program.

How can a resident appeal a nursing home's decision to transfer or discharge the resident?

A resident or family member can appeal a transfer or discharge notice by contacting the local office of the California Department of Health Services. Immediately after receiving a transfer or discharge notice, the resident or family member should telephone the Department of Health Services to request an appeal. In addition, the resident or family member should mail an appeal request to the Department of Health Services, and give a copy of that appeal request to the nursing home. (The telephone numbers for the California Department of Health Services are listed on pages 51-54 of this guide.)

After the Department of Health Services receives an appeal of a transfer

or discharge notice, the Department will schedule a hearing at the nursing home. At that hearing, a hearing officer will listen to the opinions of the resident, the resident's family members, the nursing facility staff, and any other witnesses. Approximately one week after the hearing, the hearing officer will make his or her decision; in a written decision, he or she will explain why the nursing home can or cannot transfer or discharge the resident.

How should a resident prepare for a transfer or discharge hearing?

The resident or family member should focus on the five legitimate reasons for an involuntary transfer or discharge, and prepare to show how none of those five reasons apply to the resident's situation. The resident or family member should emphasize that the nursing home's supposed reasons are not among the five legitimate reasons for an involuntary transfer or discharge.

If appropriate, the resident or family member should point out how the nursing home's inadequacies may have caused the supposed problems. In addition, the resident or family member should point out any deficiencies in the nursing home's notice; an involuntary transfer or dis-

charge will not be approved unless the original notice complied with the law.

Nursing home residents and their families may wish to be represented in a hearing by a knowledgeable attorney.

Does a resident lose his or her nursing home bed by going to a hospital for a period of time?

Not necessarily. Frequently nursing home residents leave a nursing home to go to a hospital for a period of time. A resident does not automatically lose his or her place in the nursing home during the time of that hospital stay. The law requires that a nursing home allow a resident or family to hold a nursing home bed for up to seven days of a hospital stay. Accordingly, the Medi-Cal program will pay for such a bed hold.

If a nursing home is certified to receive Medi-Cal payments (and virtually all nursing homes are), the nursing home in writing must offer a bed hold to the resident and family before the resident is transferred to the hospital. Furthermore, a resident eligible for Medi-Cal has a right to be readmitted to a nursing home even if the resident's stay in a hospital exceeds seven days. The resident must be readmitted if, at the conclusion of a hospital stay, he or she still needs nursing home care, and the nursing home has an available bed.

Despite the law discussed in the above paragraphs, nursing homes sometimes refuse to readmit residents after hospital stays. These nursing homes generally argue that they no longer can meet the resident's needs, and thus are excused from the readmission laws. In practice, this argument is almost always dishonest - the nursing home actually can meet the resident's needs, but the nursing home sees a golden opportunity to rid itself of a resident considered difficult or unprofitable.

After January 1, 2001, if a resident is refused readmission based on this or any other argument, the resident immediately should request an appeal hearing from the California Department of Health Services. (The telephone numbers for the California Department of Health Services are listed on pages 55-58 of this guide.) In general, the resident should be able to remain in the hospital until a hearing decision is issued, for two reasons. First, if the resident is eligible for Medi-Cal payment, the Medi-Cal program will pay the hospital for the resident's care until the hearing decision is issued. Second, if the resident's hospital stay is not covered by Medi-Cal or another form of payment, the hearing decision must be issued extremely

quickly - within 48 hours after the request for hearing is made.

Must a nursing home help prepare a resident for transfer or discharge?

Yes. A nursing home must adequately prepare a resident for any transfer or discharge, whether voluntary or involuntary. Federal guidelines state that this preparation could include allowing a resident trial visits to his or her new home, assuring

that a resident does not lose his or her personal possessions, and other actions.

Can a nursing home resident refuse a transfer from a Medicare room to a non-Medicare room in the same nursing home?

Yes. Under federal law, a resident has the right to refuse a transfer from one room to another if the purpose of that transfer is to shift the resident from a

RESIDENTS' RIGHTS

Medicare room to a non-Medicare room. If the resident refuses such a transfer, the Medicare program likely would no longer pay for the resident's stay, but the resident could either pay privately or arrange for Medi-Cal reimbursement (if eligible).

Nursing homes often claim that a Medicare room must be occupied by a resident who currently is receiving Medicare reimbursement for his or her nursing home stay. This claim is false. In fact, a Medicare room can be occupied by any resident. Nursing homes prefer to have a Medicare room occupied by a resident eligible for Medicare reimbursement, because the Medicare program pays a relatively high reimbursement rate.

Can a nursing home resident contest a transfer from one room to another in the nursing home, or the change of a roommate?

Federal law provides that a resident must "receive notice before the room or roommate of the resident in the facility is changed." The resident has no right to refuse the change, unless the purpose of the change is to move the resident to or from a Medicare room.

(This discussion of transfer and discharge is based primarily on Title 42 of the United States Code, sections 1395i-3(c)(1)(A)(v) and (x), and

(c)(2), and 1396r(c)(1)(A)(v) and (x), and (c)(2); Title 42 of the Code of Federal Regulations, section 483.12(a)(7); the California Health & Safety Code, section 1599.1 (h); Title 22 of the California Code of Regulations, section 72520; California Department of Health Services Memorandum PTB 92-21; California Department of Health Services Licensing and Certification Policy and Procedure Manual, section 618; and Health Care Financing Administration Memorandum of May 22, 1991, Question #17.)

This discussion of residents' rights covers three areas: a resident's access to visitors, the ability of residents and family members to influence a nursing home's operation, and a resident's right to be free of restraints. These three areas are unified by a common principle: a resident retains the basic right to control his or her own life. A resident does not forfeit rights just because he or she has been admitted to a nursing home.

When can a nursing home resident receive visitors?

A resident's family member generally must be allowed to visit the resident at any time, assuming that the resident wishes to be visited by that family member at that time. Similarly, a resident's friend generally must be allowed to visit the resident if the resident wishes to receive such a visit, although a nursing home can place "reason-

sons who are not family members.

A resident's doctor or a representative from the Ombudsman Program generally must be allowed to visit the resident at any time. A person who provides health, social or legal services to the resident must be given "reasonable access" to the resident, assuming that the resident wishes to see that person.

Do residents as a group have any say over their care?

In other words, is a nursing home a democracy? In one way, yes: a nursing home generally must establish and maintain a resident council. The resident council must include residents and may include family members (who must be invited to meetings), Ombudsman Program representatives, and nursing home employees.

A resident council may make recommendations to the nursing home. The nursing home must review and act upon these recommendations.

How can family members as a group influence the care provided by a nursing home?

Family members can organize a family council, which is a meeting of family

members (or friends) outside the presence of nursing home employees. A nursing home cannot prohibit family members from forming a family council. If requested, the nursing home must provide the family council with a meeting room and a prominent place on which to place meeting notices.

At their best, family councils are powerful organizations. A resident's family member can work within a family council to pressure a nursing home into making necessary improvements.

What is a restraint?

Federal guidelines define physical restraints broadly, stating that any device or material which "restricts freedom of movement or normal access to [a resident's] body" is a physical restraint. "Leg restraints, arm restraints, hand mitts, soft ties, vest[s], wheelchair safety bars, and geri-chairs are physical restraints." A drug "prescribed to control mood, mental

status, or behavior" is a chemical restraint.

When can a resident be restrained?

Federal law applicable to virtually all nursing homes states that a nursing home resident has "the right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms." Except for emergency situations, "restraints may only be imposed to ensure the physical safety of the resident or other residents and only upon the written order of a physician that specifies the duration and circumstances

under which the restraints are to be used."

Similarly, state law provides that restraints must be prescribed by a physician and cannot be applied for the discipline of a resident or the convenience of a nursing home's employees. Physical restraints for behavior control must be used as part of a plan to lead to less restrictive care. All physical restraints must be applied in a way that allows for speedy removal in case of an emergency.

SAFEGUARDING OF RESIDENTS' PROP-

Who decides if and when restraints should be used?

A restraint is a medical procedure. Accordingly, a restraint cannot be imposed on a resident unless the resident or the resident's representative consents to that restraint.

A resident or resident's representative should demand his or her right to determine the use of restraints on the resident. A resident or resident's representative should feel free to refuse undesired restraints, even if this choice contradicts the desires of the doctor or nursing home.

Can a nursing home insist on applying restraints unless and until a resident or the resident's representative releases the nursing home from legal responsibility for the resident's health and safety?

No. Under California law a nursing home cannot avoid its legal obligations to provide adequate care and supervision.

The nursing home can require that a resident or resident's representative make a written decision to request or refuse physical or chemical restraints. Any such written decision, however, cannot limit the nursing home's legal responsibility.

(This discussion on residents' rights is based primarily on Title 42 of the United States Code, sections 1395i-3(c)(1) and (3), and 1396r(c)(1) and (3); the Interpretative Guidelines to Title 42 of the Code of Federal Regulations, section 483.13; the California Civil Code, section 1668; the California Health and Safety Code, sections 1418.2 and 1418.4; Title 22 of the California Code of Regulations, sections 72319 and 72528; and Tunkl v. Board of Regents 60 Cal. 2d 92, 32 Cal. Rptr. 33 (1963).)

Nursing home residents often may not have the physical or mental strength to safeguard their own property. As a result, the possession and management of residents' property can create a range of potential problems. Applicable law determines if a nursing home can demand control of a resident's property, what a nursing home must do with resident property specifically entrusted to it, and what a nursing home must do to protect resident property not specifically entrusted to the nursing home.

Can a nursing home act as conservator or representative payee for a resident?

No, state regulation forbids this practice as a conflict of interest. In addition, no employee or agent of a nursing home

can act as a conservator or representative payee of a resident, unless the employee or agent is the resident's close relative.

Conservatorships are discussed on pages 45 and 46 of this guide.

Can a resident be required to deposit his or her personal funds with a nursing home?

No. This practice is prohibited by federal law applicable to virtually all nursing homes.

Can a resident require a nursing home to hold and safeguard personal funds or property of the resident?

Yes. Both federal and state law require that nursing homes offer this service.

What must a nursing home do with a resident's funds or property which the nursing home has agreed to hold and safeguard?

A nursing home generally must deposit all resident funds of over \$50 into an interest bearing account that is separate from the nursing home's operating account. Any interest accrued must be attributed properly to each resident's account. To assure that these procedures are followed, a nursing home must maintain an accounting of each resident's funds and a written record of each transaction involving those funds. The nursing home must allow a resident to review these financial records.

In addition, a nursing home must maintain a secured area which is made available for a resident's personal property at the request of the resident or family.

Must a nursing facility take any steps to safeguard a resident's property not specifically entrusted to the nursing home?

Yes. All nursing homes are required to maintain a program to reduce the loss and theft of residents' property. As a part of this program, a nursing home must inventory a resident's personal property when the resident enters the nursing home. If feasible, a nursing home must mark the personal property for identification purposes.

At the request of the resident or family, the inventory must be amended to reflect personal items brought into or removed from the nursing home. Also upon request, the nursing home must make available a copy of the inventory to the resident or family.

A nursing home must keep records of all lost or stolen personal property of at least \$25 in value. These records must include the property's description and value, the date and time the theft or loss was discovered and (if known) occurred, and the action taken by the nursing home. If stolen property is worth at least \$100, the nursing home must make a report to the local law enforcement agency.

What can a resident do to help safeguard his or her personal property?

A resident should make sure that the nursing home properly (as described above) inventories and marks the resi-

dent's personal property. In particular, the resident should ensure that glasses and dentures are marked. In general, the nursing home can be held financially responsible only for those items on the inventory.

If the resident can afford the expense, he or she should rent a safe, or buy a lock for a drawer or cabinet. Upon request, the nursing home must provide a lock for a resident's drawer or cabinet; the resident must bear the cost of such a lock.

If at all possible, the resident should not keep irreplaceable or valuable items at the nursing home.

RESIDENTS' HEALTH CARE DECISION- MAKING

Is a nursing home financially responsible for a resident's lost or stolen personal property?

Yes, in some cases. A nursing home is responsible for a resident's lost or stolen personal property if the property was on the inventory list, and the nursing home had failed to make reasonable efforts to safeguard residents' property. The nursing home's compliance with legal requirements (see the preceding paragraphs) is considered presumptive proof that the nursing home made reasonable efforts, although the resident or family member may be able to show a lack of reasonable efforts regardless of the nursing home's compliance with the legal requirements. Most nursing homes maintain insurance for lost property of residents, so residents should not hesitate to request reimbursement for losses.

Can a nursing home ask a resident to release the nursing home from its obligations to safeguard residents' personal property?

No. State law prohibits a nursing home's admission agreement from reducing the nursing home's responsibility for

residents' personal property.

(This discussion of the safeguarding of residents' property is based primarily on Title 42 of the United States Code, sections 1395i-3(c)(6) and 1396r(c)(6); the California Health and Safety Code, sections 1289.3 through 1289.5; and Title 22 of the California Code of Regulations, section 72529.)

A nursing home resident has the ability and the right to make his or her own health care decisions as long as he or she is of sound mind. If, however, a resident is mentally incapacitated (due to a stroke, coma, or another disease or accident), the resident legally can receive health care only if a legal representative for the resident authorizes the health care, or the resident previously executed adequate written instructions.

What written documents can be used to specify preferences regarding future health care?

California law authorizes three types of documents.

1. In a Durable Power of Attorney for Health Care, an individual appoints another person to make health care decisions for the individual in the future. The individual, if desired, also can list instructions regarding future health care.

2. In an Individual Health Care Instruction, an individual can list instructions regarding future health care.

3. In a Do-Not-Resuscitate form, an individual can specify that he or she is not to receive resuscitative measures.

These three documents are discussed further in the remainder of this chapter.

Why should a resident appoint another person to make health care decisions for the resident?

If a resident has no legal representative when the resident becomes mentally incapacitated, the resident may not be able to receive needed medical treatment. Likewise, a mentally incapacitated resident without a legal representative

may not be able to refuse medical treatment which will only prolong the resident's pain, even if he or she has no real prospect of recovery.

On the other hand, if a person has been appointed to make health care decisions for a mentally incapacitated resident, those decisions can be made in a way most consistent with the resident's expressed desires.

(The previous discussion applies to everyone, not just to nursing home residents. Persons of all ages and health conditions can benefit by appointing a family member or friend to make health care decisions if and when the appointing person becomes mentally incapacitated.)

How can a resident appoint another person to make health care decisions for the resident?

In California, an adult of sound mind can create a Durable Power of Attorney for Health Care. The Durable Power of Attorney for Health Care is a legally binding document which allows the person appointed (the "agent") to make health care decisions for the resident if and when the resident becomes mentally unable to make such decisions. The Durable Power of Attorney for Health Care thus allows a doctor, hospital or nursing home to

receive clear instructions even if the resident cannot make decisions.

Whom should a resident select as his or her agent under a Durable Power of Attorney for Health Care?

A resident probably should select an agent who knows the resident well, can follow the resident's wishes, and can discuss life and death issues with the resident. The agent can be a family member, friend, or other person, but must not be the resident's health care provider or an owner of a health facility.

The resident should always select one or two alternate agents in case the primary agent is unable or unwilling to act.

Can a resident give specific instructions to an agent appointed through a Durable Power of Attorney for Health Care?

Yes. A Durable Power of Attorney for Health Care form provides an optional section in which a resident can declare his or her desire to receive or not receive life-

sustaining treatment under certain conditions, or can list any instructions relating to health care decisions that he or she wishes to express.

What kinds of health care decisions can an agent make for a mentally incapacitated resident?

A Durable Power of Attorney for Health Care allows an agent to make any and all health care and treatment decisions for a mentally incapacitated resident, subject to the resident's instructions listed in the Durable Power of Attorney for Health Care. The agent can consent to diagnostic procedures and surgery, and (as discussed later in this chapter) even can decide to withhold or withdraw life-sustaining procedures.

Can a resident write health care instructions without appointing an agent?

Yes. Effective July 1, 2000, an Individual Health Care Instruction enables an individual to list his or health care instructions without appointing an agent. These instructions must be honored by future health care providers, if at that time the individual no longer is capable of making his or her own health care decisions.

In order to give adequate direction to

those health care providers, the individual should list his or her instructions as specifically as possible.

What witnessing requirements apply to the signing of either a Durable Power of Attorney for Health Care, or an Individual Health Care Instruction?

A Durable Power of Attorney for Health Care or an Individual Health Care Instruction must be witnessed by two qualified adult witnesses or notarized. If the document is being signed by an individual who is a nursing facility resident, the document also must be witnessed by a representative of the Ombudsman Program, either as one of the two adult witnesses or in addition to the notarization. (The telephone numbers for the Ombudsman Program are listed on pages 53-55 of this guide.)

A witness cannot be the appointed agent, the resident's doctor, or an employee of the nursing home. At least one of the two witnesses must be someone who is neither related to the resident nor entitled to any of the resident's property after the resident's death.

How can an resident obtain

the form for a Durable Power of Attorney for Health Care or Individual Health Care Instruction?

A form for a Durable Power of Attorney for Health Care and/or an Individual Health Care Instruction can be obtained at most hospitals or nursing homes, or by sending \$5 to the California Medical Association Publications Center, P.O. Box 7690, San Francisco, CA 94120-7690; (415) 882-5175; <http://www.cmanet.org>. A mentally competent individual can complete either form simply by following the directions on the form.

An attorney-drafted document, rather than a fill-in-the-blanks form, may be appropriate for individuals who wish to specify relatively complicated or precise instructions.

How long will a Durable Power of Attorney for Health Care or Individual Health Care Instruction remain effective?

Once completed, a Durable Power of Attorney for Health Care or Individual Health Care Instruction remains effective indefinitely. While the individual is of sound mind he or she may revoke either document at any time.

How should a resident notify others that he or she has appointed an agent through a Durable Power of Attorney for Health Care, or signed an Individual Health Care Instruction?

The resident should give copies of the document to family members, to the nursing home, and to his or her doctor and hospital. Under relevant law, a copy is just as authoritative as an original.

If desired, the resident also can register the document with the California Secretary of State ((916) 653-3984). If the resident has appointed an agent through a Durable Power of Attorney for Health Care, the resident should prepare a card that lists the telephone number of the resident's agent; this card can be kept in a wallet or purse.

Who determines when a resident can no longer make his or her own health care decisions?

Unless specified otherwise in a Durable Power of Attorney for Health Care or an Individual Health Care Instruction,

a resident's attending doctor determines the resident's capacity to make health care decisions.

Can a nursing home require a resident to sign a Durable Power of Attorney for Health Care or an Individual Health Care Instruction?

No. Federal and state law prohibit a nursing home from conditioning admission on a potential resident's possession (or non-possession) of a Durable Power of Attorney for Health Care or of any other advance directive for health care.

In addition, federal law requires that a nursing home inform an incoming resident or his or her right to accept or refuse medical treatment, and his or her ability to create a Durable Power of Attorney for Health Care or other type of advance directive. If the resident chooses to create any type of advance directive, the nursing home must document that choice in the resident's medical record.

Must a nursing home obey the decisions of an agent appointed under a Durable Power of Attorney for Health

Care, or the instructions of an Individual Health Care Instruction?

Yes, with three rare exceptions. A nursing home is not required to obey a request for health care if that health care is 1) medically ineffective, 2) contrary to generally accepted health care standards, or 3) contrary to a conscience-based policy of the nursing home. A nursing home must give its residents clear advance notice of any conscience-based policies that may affect the provision of care.

If a nursing home or other health care provider refuses to obey an appropriate decision or instruction, and none of the three above-described exceptions apply, the nursing home or provider is liable for \$2,500 or actual damages, whichever is greater, and must pay the other party's attorney's fees.

Can a family member or friend make health care decisions for a mentally incapacitated resident if the resident never appointed an agent?

According to California case law, the nearest relative of a mentally incapacitated person can make the health care decisions for that person, if no one else has been appointed to make those decisions. This case law, however, does not give a relative any formal documentation of his or her authority over the mentally incapacitated person's health care decisions. As a result, a health care provider often is hesitant to accept the health care decision of the nearest relative of a mentally incapacitated person, unless the proper decision is obvious, or unless the entire family of the mentally incapacitated person agrees with the decision of the nearest relative.

When a difficult health care decision must be made for an incapacitated resident, or when the family members and friends of an incapacitated resident disagree on the proper medical treatment, a family member or friend should seek formal, documented authority to make health care decisions on behalf of the resident. The family member or friend can petition the court 1) to be appointed conservator over the resident or 2) to be given authority to make a particular health care decision for the resident.

In a conservatorship, a court appoints someone to act indefinitely on behalf of an incapacitated adult. The person appointed (the "conservator") can be given the power to determine the medical treatment, residence, and/or finances of

the incapacitated adult (the “conservatee”).

If an incapacitated resident does not need an ongoing conservator, a family member or other interested person can petition a court for authority over a particular health care decision of the resident. Unlike a conservatorship, this procedure cannot give a family member or friend authority over the resident’s residence or finances, and expires at the conclusion of the particular medical treatment.

A family member or friend desiring a conservatorship or a particularized authorization should consult an attorney.

Who makes health care decisions for an incapacitated resident who did not previously appoint an agent, and who has no family members or friends willing to act as a legal representative?

A county’s Public Guardian Office can act as conservator for an incapacitated resident, although most Public Guardian Offices accept relatively few conservatorship cases. In addition, any interested person (including a resident’s health care provider) can apply to the court for a particularized authorization for a health care

decision.

California law authorizes an “interdisciplinary team” of a nursing home to make health care decisions for an incapacitated resident who has no legal representative. The interdisciplinary team is made up of the resident’s doctor, appropriate members of the nursing home’s staff, and, if possible, a family member or friend of the resident. The interdisciplinary team must attempt to make decisions consistent with the resident’s desires. Significantly, the interdisciplinary team only has legal authority to make relatively routine medical decisions, and specifically does not have authority to order the withholding or withdrawal of life-sustaining treatment.

Can a resident choose to make health care decisions that likely will hasten the resident’s death?

Yes. In California, any person “has the right to refuse any medical treatment or medical service, even when such treatment is labeled ‘furnishing [food and water].’ This right exists even if its exer-

cise creates a 'life threatening condition.'"

Can a resident specify that he or she is to be allowed to die under certain circumstances?

Yes. As discussed earlier in this chapter, a resident can sign a Durable Power of Attorney for Health Care which 1) will appoint an agent to make health care decisions for the resident if the resident loses the ability to make such decisions and 2) may, if the resident chooses, specify the conditions under which the resident would not wish to receive life-sustaining treatment. Also as discussed in this chapter, a resident can sign an Individual Health Care Instruction; in that form, a resident may choose to specify the conditions under which he or she would not wish to receive life-sustaining treatment.

In addition, a resident can sign a written document which authorizes a health care provider to withhold "resuscitative measures." The law requires that such a document (commonly referred to as a "Do Not Resuscitate" form) also be signed by "a physician and surgeon." The law, however, does not specify a particular format for the document, and does not require either witnesses or a notarization.

To a great extent, the "Do Not Resuscitate" form is duplicative, since an Individual Health Care Instruction also can be

used to withhold resuscitative measures. As discussed later in this chapter, however, the "Do Not Resuscitate" form is useful because it is the only advance directive form that routinely is honored by paramedics.

Finally, it should be noted that some persons list their health care desires by using written documents which are not recognized by law. For example, many persons execute a "Living Will", a document which lists a preference to receive or not receive life-sustaining medical treatment under certain circumstances. Many persons also arrange for a doctor to complete and retain a "Documentation of Preferred Intensity of Care." This document summarizes a person's formal advance directives and records his or her desires to receive or not receive life-sustaining medical treatment under certain circumstances.

There is no reason for any person to execute either a so-called "living will" or a Documentation of Preferred Intensity of Care, given that these documents are not recognized in California law. An individ-

ual interested in either a “living will” or a Documentation of Preferred Intensity of Care should instead create an Individual Health Care Instruction and/or a “Do Not Resuscitate” form, as appropriate.

Will a paramedic attempt to resuscitate a dying resident, although that resident has requested through a legal document that he or she be allowed to die?

Yes, unless the paramedic is shown that the resident has signed a “Do Not Resuscitate” form developed by a paramedic agency, or unless the resident is wearing a “Do Not Resuscitate” bracelet or medallion approved by a paramedic agency. The California paramedic agency

HOW TO RESOLVE PROBLEMS INVOLVING NURSING HOMES

has stated that California paramedics will not honor any other documentation of a request to withhold medical treatment.

Legally, the position of the California paramedic agency is wrong: like all health care providers, paramedics are obligated to honor the legal documents described earlier in this chapter. Nonetheless, in order to avoid problems, a resident should comply with the paramedics' procedures if the resident does not want to be resuscitated by a paramedic.

The "Do Not Resuscitate" form developed by the California paramedic association can be obtained from a doctor's office or a hospital. "Do Not Resuscitate" bracelets and medallions can be obtained from the Medic Alert Foundation ((800) 432-5378). These forms, bracelets and medallions are honored by paramedics throughout California.

(Of course, if the resident has executed a legal request to withhold medical treatment, the nursing home should not call for a paramedic in the first place. The above discussion is included in this guide because some nursing home employees will automatically call for a paramedic during a medical emergency, regardless of the written documents executed by a resident.)

Can a mentally incapacitated resident be allowed to die if he or she while still competent did not execute a legal request

for limited medical treatment?

Yes. A court-appointed conservator or the resident's nearest relative may have the authority to halt a resident's life-sustaining medical treatment. In addition, health care providers may accept informal, non-binding indications of a resident's treatment desires.

(This discussion of health care decisionmaking is based primarily on Title 42 of the United States Code, section 1396a(w); Title 42 of the Code of Federal Regulations, sections 489.100 through 489.104; the California Government Code, sections 27430 through 27436; the California Probate Code, sections 1800 through 1898, 2100 through 2808, 3200 through 3211, and 4600 through 4805; the California Health and Safety Code, section 1418.8, and sections 7185 through 7194.5; the California Department of Health Services District Administrator Memorandum PTB 93-18; Barber v. Superior Court 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983); Bouvia v. Superior Court 179 Cal. App. 3d 1127, 1137, 225 Cal. Rptr. 297, 300 (1986); Cobbs v. Grant 8 Cal. 3d 229, 104 Cal. Rptr. 505 (1972); Conservatorship of Drabick 200 Cal. App. 3d 185, 245 Cal. Rptr. 840 (1988); Rains v. Belshe, 32 Cal. App. 4th 157, 38 Cal. Rptr. 2d 185 (1995); a July 30, 1993 letter from Joseph Morales of the California Emergency Medical Services Authority; and an October 12, 1993 memorandum from Darlene Isbell of the Emergency Medical Services Agency of the County of Los Angeles.)

Previous chapters of this guide have described the proper, legal operation of a nursing home. This chapter suggests strategies for assuring that a nursing home com-

plies with the law and provides the care that nursing home residents deserve.

How can a nursing home problem be resolved informally?

If a resident or family member has a problem with a nursing home, he or she first should talk to the nurse or nursing assistant on duty. If the problem persists, the resident or family member should talk to a supervisor, generally the nursing home's administrator or director of nursing. If necessary, the resident or family member should request a care plan meeting.

When discussing a problem, the resident or family member should listen carefully to the nursing home's position. Many problems can be resolved through discussion and negotiation if the resident, family member and nursing home employee are willing to listen to each other.

Whenever possible, the resident or family member should rely on legal requirements (for example, the laws explained in this guide). A nursing home cannot refuse to perform a service which the law requires. If a nursing home is not following the law, the resident or family member should not back down.

What organization will help a resident or family member discuss problems with a nursing home?

Sometimes a resident or family member will make no progress by discussing a problem with a nursing home's employees. The resident or family member then may wish to call the local Ombudsman Program for assistance.

The word "ombudsman" means someone who investigates reported complaints and helps to achieve settlements. The Ombudsman Program, established by federal and state law, is completely independent from the administration of the nursing home.

Ombudsman Program representatives attempt to assure that residents of nursing homes have their problems heard and their rights protected. Ombudsman Program representatives visit California nursing homes in order to investigate possible concerns of residents. In addition, Ombudsman Program representatives will investigate problems in response to a telephone call or letter.

A person reporting a problem to the Ombudsman Program can keep his or her name confidential, if desired. Similarly, the person reporting the problem may decide whether or not to participate in the discussions between the representa-

tives of the Ombudsman Program and of the nursing home.

Ombudsman Program telephone numbers for all of California are listed on pages 53-55 of this guide.

(The Ombudsman Program always is looking for volunteers; call your local office if you would like to volunteer to help residents of nursing homes and residential care facilities.)

How can a resident or family member report a nursing home to the appropriate government agency?

If a resident or family member gets unsatisfactory results by talking with a nursing home's employees, the resident or

family member may wish to contact the California Department of Health Services. The Department's Licensing and Certification Division inspects and licenses all California nursing homes.

A resident or family member can make a complaint (confidential or otherwise)

APPENDIX

CALIFORNIA OMBUDSMAN PROGRAM OFFICES

Statewide Crisis Line: (800) 231-4024

| <i>COUNTY NUMBER</i> | <i>TELEPHONE</i> | <i>COUNTY NUMBER</i> | <i>TELEPHONE</i> |
|--------------------------|----------------------------------|--------------------------|----------------------------------|
| Alameda | (510) 465-1065 (510) 465-1153 | Kern | (661) 323-7884 |
| Alpine | (209) 532-7632 | Kings | (559) 583-0333 |
| Amador | (209) 532-7632 | Lake | (707) 468-5882 |
| Butte | (530) 898-5923 (800) 822-0109 | Lassen | (530) 223-6191 |
| Calaveras | (209) 532-7632 | Los Angeles | (800) 334-9473 (Crisis Line) |
| Colusa | (530) 898-5923 (800) 822-0109 | Arcadia | (626) 294-9123 |
| Contra Costa | (925) 685-2070 | Burbank | (818) 563-1957 (818) 563-1974 |
| Del Norte | (707) 443-9747 | Downey | (562) 869-6500 |
| El Dorado | (530) 621-6157 | Lakewood | (562) 925-7104 (562) 925-7114 |
| Fresno | (559) 447-2150 | Lancaster | (661) 945-5563 |
| Glenn | (530) 898-5923 (800) 822-0109 | Los Angeles | (213) 617-8957 (213) 617-8958 |
| Humboldt | (707) 443-9747 | Reseda | (818) 881-6460 |
| Imperial | (760) 336-3996 | San Dimas | (909) 394-0416 |
| Inyo | (760) 872-4128 | Santa Monica | (310) 393-3618 |

OMBUDSMAN OFFICES *CONTINUED*

| | | | |
|--------------------------|----------------------------------|--------------------------|----------------------------------|
| | (800) 334-9473 | Riverside | (909) 686-4402 (800) 464-1123 |
| <i>COUNTY NUMBER</i> | <i>TELEPHONE</i> | <i>COUNTY NUMBER</i> | <i>TELEPHONE</i> |
| Marin | (415) 499-7446 | Sacramento | (916) 376-8910 |
| Madera | (559) 447-2150 | San Benito | (831) 429-1913 |
| Mariposa | (209) 532-7632 | San Bernardino | (909) 388-4564 |
| Mendocino | (707) 468-5882 | Ontario | (909) 458-1353 |
| Merced | (209) 385-7402 | Victorville | (760) 243-6630 |
| Modoc | (530) 223-6191 | Yucca Valley | (760) 228-0309 |
| Mono | (760) 872-4128 | San Diego | (858) 560-2507 (800) 640-4661 |
| Monterey | (831) 333-1300 | San Francisco | (415) 751-9788 |
| Salinas | (831) 755-4471 | San Joaquin | (209) 468-3785 |
| Napa | (707) 255-4236 | San Luis Obispo | (805) 772-3059 |
| Nevada | (530) 274-2825 | San Mateo | (650) 295-2188 |
| Orange | (714) 479-0107 | Santa Barbara | (805) 563-6025 |
| Placer | (530) 823-8422 | Santa Maria | (805) 928-4808 |
| Plumas | (530) 898-5923 (800) 822-0109 | Santa Clara | (408) 944-0567 |

OMBUDSMAN OFFICES *CONT.*

Santa Cruz (831) 429-1913

Shasta (530) 223-6191

*COUNTY
NUMBER TELEPHONE*

Sierra (530) 274-2825

Siskiyou (530) 223-6191

Solano (707) 644-4194

Sonoma (707) 526-4108

Stanislaus (209) 529-3784

Sutter (530) 755-2018

Tehama (530) 898-5923
(800) 822-0109

Trinity (530) 223-6191

Tulare (559) 583-0333

Tuolumne (209) 532-7632

Ventura (805) 656-1986

Yolo (530) 668-5775

Yuba (530) 755-2018

CALIFORNIA DEPARTMENT OF HEALTH SERVICES OFFICES*COUNTY
NUMBER TELEPHONE*Alameda (510) 540-2417
(800) 554-0352Alpine (916) 229-3400
(800) 554-0354Amador (916) 229-3400
(800) 554-0354Butte (530) 895-6711
(800) 554-0350Calaveras (916) 229-3400
(800) 554-0354Colusa (530) 895-6711
(800) 554-0350Contra Costa (510) 540-2417
(800) 554-0352

DEPARTMENT OF HEALTH SERVICES *CONTINUED*

| | | | |
|---------------|----------------------------------|---------------|----------------------------------|
| Del Norte | (707) 576-2380 (800) 554-0349 | Lassen | (530) 895-6711 (800) 554-0350 |
| El Dorado | (916) 229-3400 (800) 554-0354 | | |
| <i>COUNTY</i> | <i>TELEPHONE</i> | <i>COUNTY</i> | <i>TELEPHONE</i> |
| <i>NUMBER</i> | | <i>NUMBER</i> | |
| Fresno | (559) 437-1500 (800) 554-0351 | Los Angeles | (323) 837-1005 (800) 228-1019 |
| Glenn | (530) 895-6711 (800) 554-0350 | Commerce | (323) 869-8521 |
| Humboldt | (707) 576-2380 (800) 554-0349 | Culver City | (310) 665-8400 |
| Imperial | (619) 688-6190 (800) 824-0613 | Downey | (562) 401-8087 |
| Inyo | (909) 383-4777 (800) 344-2896 | Van Nuys | (818) 901-4375 |
| Kern | (805) 654-4800 (800) 547-8267 | West Covina | (626) 962-3357 |
| Kings | (559) 437-1500 (800) 554-0351 | Madera | (559) 437-1500 (800) 554-0351 |
| Lake | (707) 576-2380 (800) 554-0349 | Marin | (650) 301-9971 (800) 554-0353 |
| | | Mariposa | (559) 437-1500 (800) 554-0351 |

DEPARTMENT OF HEALTH SERVICES *CONTINUED*

Mendocino (707) 576-2380
(800) 554-0349

Merced (559) 437-1500
(800) 554-0351

Modoc (530) 895-6711
(800) 554-0350

COUNTY TELEPHONE
NUMBER

Mono (909) 383-4777
(800) 344-2896

Monterey (408) 277-1784
(800) 554-0348

Napa (707) 576-2380
(800) 554-0349

Nevada (530) 895-6711
(800) 554-0350

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