Bet Tzedek Legal Services is a non-profit, public interest law center which provides free legal services to low-income residents of Los Angeles County. Bet Tzedek means “House of Justice” in Hebrew. Bet Tzedek serves persons of all racial, religious and ethnic backgrounds.

Los Angeles Fairfax Office
145 South Fairfax Avenue, Suite 200
Los Angeles, California 90036
323.939.0506

San Fernando Valley Office
12821 Victory Boulevard
North Hollywood, California 91606
818.769.0136

Los Angeles Mid-Wilshire Office
3435 Wilshire Boulevard, Suite 470
Los Angeles, California 90010
213.384.3243

www.bettzedek.org
# TABLE OF CONTENTS

**About the Author, Acknowledgments, and Dedication** ........................................ vi

**Introduction** ................................................................................................................. 1

1 Finding the Right Nursing Home .................................................................................. 4
   Long-Term Care Options .................................................................................................. 4
   Key Factors in Selecting a Nursing Home ...................................................................... 8
   Final Thoughts .............................................................................................................. 13
   Resources ..................................................................................................................... 14

2 Paying for Nursing Home Care ..................................................................................... 18
   Overview of Costs and Payment Options ..................................................................... 18
   Medicare ....................................................................................................................... 20
   Medicare HMOs ........................................................................................................... 25
   Medi-Cal ....................................................................................................................... 28
   Long-Term Care Insurance .......................................................................................... 36
   Resources ..................................................................................................................... 38

3 Admission to a Nursing Home ....................................................................................... 42
   Know Your Rights. ......................................................................................................... 42
   Admission Decisions ...................................................................................................... 43
   Admission Agreements ................................................................................................. 43
   Payment Provisions ..................................................................................................... 44
   Common Problems with Admission Agreements ....................................................... 48
   Resources ..................................................................................................................... 52
4 Quality of Care ........................................................... 56
General Care Standards. .................................................. 56
Care Planning Process ....................................................... 57
Specific Care Standards and Residents’ Rights. ...................... 59
Resources .................................................................. 66

5 Transfers and Discharges .................................................. 70
Lawful and Unlawful Reasons. ................................................ 70
Notice Requirements........................................................ 72
Discharge Planning Requirements ....................................... 72
Appeals ........................................................................ 73
Readmissions from Hospitals ............................................ 76
Transfers within Nursing Homes ......................................... 77
Resources ..................................................................... 79

6 Protecting Residents’ Property .......................................... 82
Residents’ Funds ............................................................. 82
Residents’ Personal Property ............................................. 82
Protections Against Financial Abuse .................................. 84
Resources ..................................................................... 86
ABOUT THE AUTHOR

Jody Spiegel

Jody Spiegel, an attorney and Director of the Nursing Home & Assisted Living Advocacy Project at Bet Tzedek, has specialized in the laws governing nursing homes and assisted living facilities since 2001. Through legal and legislative advocacy, community partnerships, and education, she works to improve the quality of care and quality of life for older and disabled adults. She counsels consumers, attorneys, and advocates throughout California on long-term care issues, and represents facility residents and their families in administrative hearings and litigation. She also is a frequent lecturer to community and professional organizations, and the author of several publications for attorneys and consumers on nursing homes and assisted living. Ms. Spiegel has served on numerous government workgroups and statewide committees involving long-term care, and is on the Board of Directors of the California Advocates for Nursing Home Reform and the Assisted Living Consumer Alliance. She also is a member of the WISE & Healthy Aging Advisory Council.

ACKNOWLEDGMENTS

The author and Bet Tzedek would like to thank Eric Carlson of the National Senior Citizens Law Center for his extensive work in developing and writing the initial editions of the Nursing Home Companion while employed at Bet Tzedek. Milbank, Tweed, Hadley & McCloy LLP provided invaluable research and writing assistance for this edition of the guide. Helpful comments were provided by Eric Carlson; Tony Chicotel, Mike Connors, and Patricia L. McGinnis of the California Advocates for Nursing Home Reform; Molly Davies of WISE & Healthy Aging; and Janet Morris, Shayla Myers, Grant Specht, and Kim Williams of Bet Tzedek. We appreciate tremendously the time, expertise, and assistance of these dedicated advocates.

Special thanks to the author’s husband, Dan Reddington, for his proofreading, support, and love.

DEDICATION

This book is dedicated to my parents, Carole Spiegel and Phillip Spiegel, whose passion for social justice is hard-wired into my DNA.

IMPORTANT NOTE

Every attempt was made to ensure the accuracy of the information in this guide. Bet Tzedek Legal Services reserves the right to revise the guide at any time—without notice—and assumes no liability for damages incurred directly or indirectly as a result of errors, omissions, or discrepancies.

Since relevant laws change from year to year, please make sure to review the most recent edition of this guide. Resources identified in this guide may be useful to the reader. Such references do not constitute an endorsement by Bet Tzedek Legal Services of the programs or services of those enterprises.
Your mother has suffered a stroke and is about to be discharged from the hospital. The physician tells you that your mother is not well enough to return home and that she should be placed in a nursing home.

How can you identify a quality nursing home? What resources are available to help pay for nursing home care? How can you ensure the best care possible for your loved one?

This guide provides a starting point to answer these and other questions, including how to:

- find a nursing home
- pay for nursing home care
- ensure quality of care
- make appropriate healthcare decisions
- resolve problems involving nursing homes

Remember, knowledge is power. This guide is intended as a reference source for nursing home residents and their families, friends, and advocates. Use this guide in conjunction with visits to nursing homes, discussions with representatives of the local Ombudsman Program, and, if necessary, consultations with a qualified attorney. The more information you have about nursing homes and your rights, the easier it will be for you to make good decisions and advocate for better care.

Bet Tzedek’s *Nursing Home Companion* is based on federal law and the laws of California. If you live in a state other than California, make sure that you check the laws of your own state. In addition, relevant laws change from year to year. Always consult local experts to supplement and verify the information contained in this guide and visit Bet Tzedek at www.bettzedek.org/resources for updates.
Sound familiar? If you are reading this guide, you or your loved one may need ongoing assistance with health care. Some individuals are not physically or mentally able to continue living in their current residences. The solution may involve moving into a nursing home temporarily or permanently.

This chapter provides an overview of long-term care options, and then focuses on how to select a nursing home that meets your needs, or the needs of your loved one.

**Long-Term Care Options**

Options for long-term care have increased dramatically over the past few decades. Older adults and their families now have many choices for care, including services to enable individuals to remain at home, assisted living, continuing care retirement communities, and nursing homes.

Whenever possible, decisions about where to receive long-term care should stem from conversations among the people who need care, their family and friends, and healthcare professionals. Communication is critical. It must include frank discussions of the person’s changing needs and the resources available to meet those needs.

Discussions with physicians, social workers, and care managers may be helpful in dealing with medical, emotional, and financial issues. Depending on the health and financial resources of the individual, and the availability of family and friends to provide assistance, a nursing home may not be the best option.

Let us look briefly at the different places where an individual can receive long-term care.

**Remaining at Home**

Various services can help older adults continue living in their home or the home of a family member. Visiting nurses or home health agencies can provide necessary health care at home. Home care workers can provide assistance with dressing, cooking, cleaning, and chores. Community groups can provide home-delivered meals and transportation to medical appointments. Adult daycare programs can provide care during the day while family members are at work.

Many cities provide free or low-cost repairs
or modifications to the homes of older or disabled adults who cannot afford to pay on their own. Medicare and Medicaid—called Medi-Cal in California—may pay for certain other home care expenses.

**Visiting nurses can provide necessary health care at home.**

Paying for Home Care with Medicare
The Medicare program pays for home health care for Medicare beneficiaries who are homebound and require skilled nursing care or rehabilitative therapy. All services are limited to part-time or intermittent care. The resident’s physician must review the person’s condition every 60 days to determine whether he still needs skilled care.

Medicare also pays for hospice and end-of-life, *palliative* (or comfort) care for Medicare beneficiaries. The patient’s physician must certify that the patient is terminally ill with six months or less to live and that the patient wants to receive comfort care instead of curative care.

Paying for Home Care with Medi-Cal
Like Medicare, the Medi-Cal program pays for skilled nursing and rehabilitative care in an individual’s home. Unlike Medicare, Medi-Cal also pays for additional services to assist older adults to remain at home. These services include:

- Aide workers through the In-Home Supportive Services Program (IHSS)
- Case management, respite care, and home modifications through the Multipurpose Senior Services Program (MSSP)

Keep in mind, though, that Medi-Cal and its services are available only to individuals with limited finances.

**The Medicare and Medi-Cal programs both pay for skilled nursing and rehabilitative care in an individual’s home.**

**TO LEARN MORE**

Comprehensive information about caring for a loved one at home can be found in Bet Tzedek’s *The Caregiver Companion*. *The Caregiver Companion* may be ordered online at www.bettzedek.org/resources or by calling (323) 549-5897. It also is available for download at www.bettzedek.org/resources.

**Assisted Living Facilities**
Assisted living facilities—also known as residential care facilities, board-and-care homes, retirement homes, and rest homes—provide residents with a room, meals, housekeeping, supervision, and assistance with *activities of daily living*. Activities of daily living include feeding, dressing, toileting, and bathing. In California, assisted living facilities that serve people age 60 or older (or younger people with similar needs) are called “residential care facilities for the elderly.”
Assisted living is for people who are unable to live by themselves, but do not need 24-hour nursing care. Assisted living facilities are not required to have physicians, nurses, or nurse assistants on staff. However, medical services may be provided by a home health agency working with an assisted living facility.

**Assisted living facilities provide residents with a room, meals, housekeeping, supervision, and assistance with activities of daily living.**

More and more assisted living facilities are admitting and retaining residents with serious health conditions. For example, an assisted living facility may be able to care for a resident who cannot turn in bed, is incontinent, has severe dementia, or is terminally ill.

In many cases, assisted living facilities care for individuals who in the past would have had only one option—a nursing home. This increased capability of assisted living facilities has advantages and disadvantages.

On one hand, older adults have more options to meet their particular needs. On the other hand, the quality of care in some of these facilities does not meet acceptable standards because they are not required to have physicians or nurses on their staff.

**TO LEARN MORE**

Assisted living facilities in California are licensed, regulated, and inspected by the California Department of Social Services, Community Care Licensing Division (www.ccld.ca.gov). More information about assisted living facilities is located in the *Assisted Living Companion*, Bet Tzedek’s consumer guide to assisted living laws and practices. The *Assisted Living Companion* may be ordered online at www.bettzedek.org/resources or by calling (323) 549-5897. It also is available for download at www.bettzedek.org/resources.

**Continuing Care Retirement Communities**

Continuing Care Retirement Communities (CCRCs) provide housing (independent living space), assisted living care, and nursing care, usually in one location. Residents typically pay a large entrance fee at admission. They
Finding the Right Nursing Home

Finding the Right Nursing Home

also sign a contract that may entitle them to receive appropriate levels of care throughout their lifetime.

Nursing Homes

Nursing homes—also known as nursing centers, convalescent hospitals, skilled nursing facilities, and rehabilitation centers—provide medical, nursing, and rehabilitative care. Residents of nursing homes often cannot walk without assistance. They generally need help in performing one or more activities of daily living. Nursing home residents may also suffer from substantial memory loss.

Nursing homes provide medical, nursing, and rehabilitative care.

The staff of nursing homes may include these and other healthcare professionals:

- Administrators
- Social Workers
- Registered Nurses
- Licensed Practical/Vocational Nurses
- Certified Nursing Assistants
- Respiratory Therapists
- Physical Therapists
- Physical Therapy Assistants
- Registered Dietitians

Nursing homes must also have ready access to physicians.

Some nursing homes provide care only for residents with psychiatric disorders. Others offer specialized care within separate areas in the nursing home, such as Alzheimer units.

Nursing Homes in California are licensed, regulated, and inspected by the California Department of Public Health, Licensing and Certification Division (www.cdph.ca.gov/programs/LnC), (916) 552-8700 or (800) 236-9747. (For phone numbers of local District Offices, see App. C, pages 118–120.)

TO LEARN MORE

CCRCs are regulated primarily by the California Department of Social Services (www.calcrr.ca.gov). CCRCs that operate skilled nursing facilities must also be licensed by the California Department of Public Health, Licensing and Certification Division (www.cdph.ca.gov/programs/LnC). Additional information about CCRCs is available from the California Advocates for Nursing Home Reform at www.canhr.org/CCRC.
Key Factors in Selecting a Nursing Home

After an individual has decided that a nursing home is the appropriate long-term care option, he needs to select which nursing home will best meet his needs.

Searching for a nursing home can be difficult. Most people know very little about nursing homes. Often a prospective resident is in a hospital and will be discharged soon.

No matter the situation, prospective residents and family members should search carefully for the best available nursing home. Such a search may prevent many future problems.

Let us take a look at several key factors in the selection of a nursing home, including location, quality of care, staff, medical providers, care philosophies, special care units, payment policies, admission agreements, and referrals by professionals. (For more information, see the “Nursing Home Checklist” in Appendix A, pages 112–114.)

Location

Just as in house-hunting, location is a key factor. Whenever possible, the selected nursing home should be located near the resident’s family members and friends. Nursing home residents with frequent visitors generally do better physically and emotionally than residents without visitors.

If a person is unable to live in a nursing home near family members and friends, check to see whether a local church, synagogue, or senior center can send people to visit the resident.

Nursing home residents with frequent visitors generally do better physically and emotionally than residents without visitors.

Quality of Care

Although the vast majority of nursing homes try to provide quality care, some facilities fall short of even minimum requirements. To make sure that an individual is placed in the most suitable environment, prospective residents and family members should visit each nursing home being considered. They should also inspect each facility’s official records for penalties and citations.

Visiting a Prospective Nursing Home

During the visit, the prospective resident and family members should talk with current residents and their visitors. They will know better than anyone else the pluses and minuses of the nursing home.

Look at rehabilitation rooms. Some therapies require particular equipment, such as a treadmill, recumbent bicycle, or shoulder pulleys. If certain pieces of equipment are needed for the resident’s care, make sure that the nursing home is equipped with the devices and that they are in good working order.

TIP: If possible, visit the nursing home several times. Visit on a weekday, during a weekend, at night, and during a meal. Check to see whether residents’
KEY QUESTIONS FOR VISITS TO PROSPECTIVE NURSING HOMES

Prospective residents and their family members should try to answer these questions when visiting a potential nursing home:

- Are the residents up, dressed, and engaging in activities?
- Is the general atmosphere warm, pleasant, and cheerful?
- Can you detect any strange odors when first entering the facility or as you move throughout the hallways?
- Are the rooms and hallways clean and neat?
- Do residents appear well-groomed?
- Does the staff treat residents with respect?
- Does the staff respond to residents’ needs in a timely manner?

Examining Official Records

The prospective resident and family members should examine the nursing home’s inspection records, prepared by the California Department of Public Health (CDPH). The CDPH is required to inspect each nursing home at least once every 15 months. The CDPH’s inspection records summarize its findings and list monetary penalties assessed against nursing homes in response to particularly bad conditions.

TO LEARN MORE

Summaries of each Medicare- and Medicaid-certified nursing home’s inspection records and other helpful information may be found at www.medicare.gov/NHCompare, the federal government’s Nursing Home Compare website. The site provides numerous resources for finding and evaluating nursing homes, including the ability to search by name, zip code, city, county, or state; health and fire safety inspection results; nursing home staff data; quality measures; complaint investigations; and enforcement actions and penalties.

Similar summaries and extensive information are provided by the California Department of Public Health’s Health Facilities Consumer Information System at http://hfcis.cdph.ca.gov, the California Advocates for Nursing Home Reform at www.nursinghomeguide.org, and the California HealthCare Foundation at http://www.calqualitycare.org.
Finding the Right Nursing Home

Each nursing home must make available a copy of its most recent inspection report to any prospective resident. In addition, local District Offices of the CDPH provide public access to inspection records of nursing homes within their districts. Information about the availability of these inspection records can be obtained by calling the phone numbers listed in Appendix C, pages 118–120.

Staff
Prospective residents and family members should talk to the administrator, director of nursing, and social services director of each nursing home under consideration. Ask the administrator and director of nursing to explain which person at the nursing home is responsible for particular tasks and how the administrators know that those tasks have been completed. Ask who will provide feedback to the resident and family members and who will accept inquiries or complaints about the resident’s care.

Ask how the nursing home provides rehabilitation therapy, including physical, speech, occupational, and respiratory therapy. Ideally, the various therapists should be available throughout the day every day of the week. Ask about the therapists’ qualifications and specialties and whether the therapists work exclusively for one nursing home or several.

Do the staff members seem to recognize residents as individuals and accommodate individual needs and preferences?

Examine the nursing home’s activity schedule. It should contain a variety of activities including evening and weekend activities. Ask the social services director whether activities are led by a member of the activities staff. If nursing staff or volunteers lead the activities, the activities are more likely to be canceled due to a lack of time or preparation. Also ask if the home’s resident council meets regularly and whether it has a family council. (For more information on those councils, see Chapter 8, page 105.)

During all these discussions, prospective
residents and family members should be aware of the general attitudes of the nursing home staff. Do the staff members seem to recognize residents as individuals and accommodate individual needs and preferences? Or do they routinely require that all residents conform to the same schedule?

**Access to Physicians**
Many physicians choose not to visit nursing homes or will visit only certain nursing homes. If prospective residents and family members want to make sure their medical providers will visit a particular nursing home, they should check with their providers as soon as possible.

**Philosophy of Care**
A primary criticism of nursing homes has been their tendency to treat residents as medical cases rather than human beings. In response to this failing—and because of increased competition—better nursing homes now place more emphasis on creating homelike environments and finding ways to better meet an individual resident’s needs.

Some nursing homes, for instance, may offer private rooms, extensive menus for meals, specialized field trips, or pet therapy. Nursing homes with these person-centered policies often participate in one or more of the following organizations:

- California Culture Change Coalition
  www.culturechange.org
- Eden Alternative
  www.edenalt.com
- The Green House Project
  www.thegreenhouseproject.org
- Pioneer Network
  www.pioneernetwork.net

Ask the staff if the nursing home participates in one of these programs. Regardless of whether it does, ask what steps the nursing home takes to make its residents feel more at home. Nursing homes in California generally receive about $7,000 a month for the care of one resident. A nursing home seeking payment of such a significant amount of money should be able to explain how the particular needs and preferences of residents and their families would be met.
Special Care Units
Some nursing homes advertise that they provide special care for patients with dementia or other conditions. Such claims of “special” care may or may not be meaningful. In most cases there are no set laws or industry standards for specialization. A nursing home’s claim that it has a special care unit may mean only that the facility’s marketing department decided to emphasize that particular health condition.

TIP: Do not automatically accept claims of specialization. If a nursing home has a unit that is truly specialized, the staff should be able to explain what distinguishes the care it provides from the care provided by other nursing homes.

Medi-Cal Reimbursement Policies
The vast majority of nursing homes in California participate in the Medi-Cal program. Prospective residents who have limited financial resources should confirm that the nursing home

---

**ASK THE EXPERTS—ACCOMMODATING THE RESIDENT**

*How can I tell if the nursing home accommodates the wishes of its residents?*

Prospective residents and their family members should make sure that the nursing home is willing to accommodate resident preferences. To help you determine the level of that willingness, in the spaces below write four or five preferences important to the prospective resident. Such preferences might include a preferred mealtime or shower time, dietary accommodations, use of a nightlight, or “sleeping in.”

Then check the box on the right that most closely describes the response of the nursing home. If the home seems resistant to these preferences, it may be best to look elsewhere. On the other hand, it is a good sign if the nursing home seems willing to accommodate these preferences.

<table>
<thead>
<tr>
<th>Preferences</th>
<th>Highly Willing</th>
<th>Somewhat Willing</th>
<th>Not at All Willing</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. _____________</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>2. _____________</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>3. _____________</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>4. _____________</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>5. _____________</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>
is certified to accept Medi-Cal reimbursement. Nursing homes not certified to receive Medi-Cal reimbursement may evict or transfer residents who exhaust their savings and become eligible for the Medi-Cal program after originally paying privately for nursing home care.

**Admission Agreements**

Prospective residents and family members should examine and consider the admission agreement used by each nursing home. Some nursing home admission agreements contain provisions harmful to residents and their families. (See Chapter 3, pages 42–53.) State law requires that a nursing home make copies of its admission agreement available to the public. The nursing home may charge a small fee for this copy.

**Referrals by Professionals**

Prospective residents and family members may wish to get recommendations for nursing homes from healthcare professionals, hospital discharge planners, and referral services. It is best to use these recommendations together with visits to nursing homes and other key factors discussed in this chapter.

Healthcare professionals and hospital discharge planners may be able to provide valuable information about nursing homes. However, some discharge planners automatically refer patients to certain nursing homes simply for the 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.

**TIP:** Contact your local Long-Term Care Ombudsman Program for referrals to nursing homes. The Ombudsman Program will make referrals based on the needs of a prospective resident, but will not give recommendations. Ombudsman are resident advocates, and do not receive payments from nursing homes for referrals. For phone numbers of local Ombudsman Programs, see Appendix B, pages 115–117.

Similarly, prospective residents and family members should not automatically rely on nursing home referral services. Some services may work from inadequate and out-of-date nursing home lists. Some services receive money from nursing homes for each resident the service places in those particular nursing homes. Those referral services should be used with caution. They have an incentive to place residents in nursing homes that will pay for the referral, even though the nursing homes may not provide acceptable care.

**Final Thoughts**

Searching for a nursing home is not easy, particularly considering the emotions involved and the limited time typically available. Unfortunately, no scientific formula exists to determine the “best” facility for any individual.

Although internet sites can provide helpful information about nursing homes, that information is only a starting point for a search. To the extent possible, set your sights high, and do not be shy about seeking competent, personalized care.
RESOURCES

For more information on topics in this chapter, consult the following agencies, print and online resources, and the legal citations on which the information is based.

Agencies

- Bet Tzedek Legal Services: www.bettzedek.org, (323) 939-0506

- California Department of Public Health, Licensing and Certification Division: www.cdph.ca.gov/programs/LnC, (800) 236-9747. (For phone numbers of local District Offices, see Appendix C, pages 118–120.)

- California Department of Social Services, Community Care Licensing Division: www.ccld.ca.gov, (916) 651-8848

- California Long-Term Care Ombudsman Program: www.aging.ca.gov/programs (search: “ombudsman”), CRISISline (800) 231-4024. (For phone numbers of local Ombudsman Programs, see Appendix B, pages 115–117.)

Print

- Bet Tzedek Legal Services, Assisted Living Companion (print and download versions): www.bettzedek.org/resources, (323) 549-5897

- Bet Tzedek Legal Services, The Caregiver Companion (print and download versions): www.bettzedek.org/resources, (323) 549-5897

Online

- California Advocates for Nursing Home Reform: www.nursinghomeguide.org, (800) 474-1116

- California Culture Change Coalition: www.calculturechange.org

- California Department of Public Health: http://hfcis.cdph.ca.gov, (800) 236-9747

- California HealthCare Foundation: www.calqualitycare.org


- Eden Alternative: www.edenalt.com

- Pioneer Network: www.pioneernetwork.net

- The Green House Project: www.thegreenhouseproject.org

Legal Citations

The discussions in this chapter are 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, sections 483.10(g) and 488.308(a).
CHAPTER 2
PAYING FOR NURSING HOME CARE
Nursing home care is expensive. While some nursing home residents may have enough income or savings to pay for nursing home care, the majority of Californians rely at least in part on the Medi-Cal program and to a lesser extent on the Medicare program and private insurance policies.

This chapter examines nursing home costs and then discusses payment options, including Medicare, Medicare Health Maintenance Organizations (HMOs), Medi-Cal, and long-term care insurance.

Overview of Costs and Payment Options
Nursing home care costs vary widely and by region. Most California nursing homes charge between $5,000 and $10,000 per month. On average, a private room at a nursing home costs approximately 15% more than a semi-private (shared) room. Physician visits and certain services and supplies may create additional charges.

Charges for Services and Supplies
A nursing home must provide residents with monthly statements listing all items for which they are being charged.

Some nursing homes impose separate charges for services and supplies, such as therapy sessions, catheter equipment, or towels. The admission agreement must clearly state which services and supplies are included in its basic daily rate, which items are optional, and what the charges are for optional items. A nursing home must provide at least 30 days written notice to residents of any increase in its daily rate or charges for optional services.

If a nursing home bills for an item not clearly described in its admission agreement, a resident should request that the item be removed from the bill.

Nursing homes may not impose separate charges for items unless the resident in the admission agreement agrees to pay specific, separate charges for those items. Residents are

ASK THE EXPERTS—NURSING HOME CHARGES
I just received last month’s nursing home bill. The nursing home is charging me $7,610: $7,000 for the monthly rate, plus $610 for other items and services. These “extra” charges include therapy, catheter supplies, Kleenex, syringes, and bed pads. The nursing home’s admission agreement did not list the amount of these extra charges. Do I have to pay them?

No, you do not. Because the extra charges were not listed in the admission agreement, you are not responsible for them. You should immediately request that the charges be removed from your bill. In addition, if you are eligible for Medicare or Medi-Cal, the nursing home cannot bill you separately for services or items covered by these programs.
not obligated to pay for services or supplies that are not listed as separate cost items in the admission agreement. If a nursing home bills for an item not clearly described in its admission agreement, a resident should request that the item be removed from the bill.

Medicare and Medi-Cal Coverage
Both Medicare and Medi-Cal pay for nursing home care under some circumstances. The Medicare program pays only for short-term nursing home stays of 100 days or fewer. In contrast, Medi-Cal pays for all nursing home costs for qualified individuals, no matter how many days they are in the facility.

If a resident is eligible for either the Medicare or Medi-Cal program, a nursing home cannot bill the resident for services or supplies covered by the program. The coverage of both programs is extremely broad.

For example, Medi-Cal’s basic daily rate covers room and board (including laundry service) and all routine nursing services. Medi-Cal also covers a limited number of physician visits, prescriptions, eyeglasses, hearing aids, prosthetic devices, adult briefs, and ambulance services. The program does not cover beauty shop services, though shampooing, hair cutting, and nail clipping are included as part of routine nursing services.

Medi-Cal pays for all nursing home costs for qualified individuals, no matter how many days they are in the facility.

Differences Between Medicare and Medi-Cal
In California, the Medicaid program is known as Medi-Cal. Under both Medicare and Medi-Cal, an adult beneficiary must generally be at least 65 years old or disabled. Here are some key differences between the Medicare and Medi-Cal programs:

- **Under Medicare**, a beneficiary or a beneficiary’s spouse must usually have made certain contributions, through payroll deductions, to the Social Security program. The beneficiary’s income and resources are irrelevant.

- **Under Medi-Cal**, a beneficiary need not have contributed to the Social Security program, but must have limited resources and income.

---

SAME-SEX COUPLES AND REGISTERED DOMESTIC PARTNERS

The Medicare and Medi-Cal programs pay for most nursing home care in California. Currently, same-sex couples and registered domestic partners do not receive the same spousal benefits as opposite-sex married couples under the Medicare and Medi-Cal programs. The laws in this area are complex and constantly changing. Contact a knowledgeable attorney to discuss your specific circumstances and visit Bet Tzedek at www.bettzedek.org/resources for updated information.
The Medicare program is similar to a health insurance policy purchased from the federal government through premiums deducted from payroll checks. Medi-Cal is a safety-net program provided by California and the federal government for individuals with little or no money to pay for medical expenses.

**Medicare**

Medicare is a health insurance program administered by the federal government. It pays medical bills for qualified older and disabled adults, but its nursing home coverage is limited.

**Medicare Eligibility**

In general, individuals are eligible for Medicare if they are at least 65 years old and they or their spouse have worked at least ten years in employment covered by Medicare. Because Social Security eligibility also requires ten years of covered employment, eligibility for Medicare is often tied to eligibility for Social Security. Specifically, if a person is receiving Social Security retirement benefits, then the person and her spouse are each eligible for Medicare on their respective 65th birthdays.

Individuals may be eligible for Medicare prior to their 65th birthday if they are disabled or have certain serious medical problems. For example, a person of any age becomes eligible for Medicare after receiving Social Security disability benefits for at least two years. A person suffering from kidney failure becomes eligible for Medicare within three months, assuming the person or her spouse has an adequate work history.

TO LEARN MORE

The Centers for Medicare & Medicaid Services (CMS), a branch of the U.S. Department of Health and Human Services, is the federal agency that administers the Medicare program and monitors the Medicaid programs offered by each state. For questions about Medicare eligibility, enrollment, benefits, or claims, visit www.MyMedicare.gov or call (800) MEDICARE (633-4227).

Personalized counseling for Medicare beneficiaries is available from the California Department of Aging’s Health Insurance Counseling and Advocacy Program (HICAP) at (800) 434-0222 or www.aging.ca.gov/hicap. HICAP counselors can assist with choosing Medicare plans, filing Medicare claims, and preparing Medicare appeals.

**Medicare Parts A, B, C, and D**

There are four types of Medicare insurance: Parts A, B, C, and D. Let us look at each of them and what they cover.

**Medicare Part A**

Medicare Part A is commonly known as “hospital insurance.” Medicare Part A pays
Medicare Part A
Medicare Part A is commonly known as “hospital insurance.” Medicare Part A pays for hospital stays, skilled nursing facility stays, hospice care, and home health care for a stay in a hospital or a nursing home for qualified individuals. It also pays for certain expenses of home health care and hospice care for a terminally ill person.

Medicare Part B
Medicare Part B is commonly known as “medical insurance.” Medicare Part B pays for certain physician services, therapies, laboratory tests, x rays, and medical equipment. Under some circumstances, Medicare Part B pays for particular services provided in a nursing home or for home health care.

Medicare Part C
Medicare Part C is commonly known as “Medicare Advantage,” and combines both Part A and B coverage. Instead of the federal government providing coverage, this coverage is provided by private insurance companies approved by Medicare. Medicare Advantage Plans include Medicare Health Maintenance Organizations (HMOs). Medicare HMOs must provide at least the same benefits as are available under Medicare Parts A and B, including payment for qualifying nursing home stays.

Medicare Part D
Medicare Part D is Medicare’s prescription drug coverage. If a resident’s nursing home stay is covered under Part A, the resident’s prescription drugs are covered under Part A instead of Part D.

Medicare Coverage for Nursing Home Care
The Medicare program will pay for nursing home care only for a limited time period, and only if an individual meets all the following conditions:

- The individual has Medicare Part A coverage and days left in her benefit period.
- A physician certifies that the individual needs nursing home care.

Identifying Whether You Have Medicare Part A or B
If you are not sure whether you have Medicare Part A or Part B (or both), look on your red, white, and blue Medicare card (see below). If you have Medicare Part A or B, it will show “Hospital (Part A)” or “Medical (Part B)” on the lower left corner of the card. The card also shows the effective date of coverage. You can also get this information by calling your local Social Security office or (800) 772-1213.
• The individual is admitted to a nursing home typically within 30 days of a consecutive three-day qualifying hospital stay.

• The individual needs daily skilled nursing or rehabilitation services.

• The nursing home is a Medicare-certified provider.

Services Covered by Medicare
Medicare Part A pays nursing home charges only for residents who need “skilled nursing or skilled rehabilitation services” every day. Skilled nursing services, as defined by Medicare, include intravenous feeding, the treatment of widespread skin disorders, and the monitoring of residents who require relatively sophisticated evaluations.

Medicare Part A pays nursing home charges only for residents who need “skilled nursing or skilled rehabilitation services” every day.

Skilled rehabilitation services include, but are not limited to, “range of motion” exercises, services provided by a speech pathologist, and physical, occupational, or speech therapy.

Conditions that do not ordinarily require skilled services may require them because of special circumstances. For example, a plaster cast on a leg does not usually require skilled care, but if a patient needs traction or has a preexisting acute skin condition, skilled personnel may be needed. This treatment would then qualify for Medicare Part A payments.

ASK THE EXPERTS—“SKILLED” SERVICES?

Aren’t all services provided by a nursing home “skilled” and eligible for Medicare Part A reimbursement?

No, they are not. Most long-term residents of nursing homes do not receive “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 repositioning of residents to avoid bedsores—do not qualify a resident for Medicare Part A payment of nursing home charges.

TIP: Some nursing homes incorrectly claim that Medicare Part A cannot pay for nursing home care unless a resident’s condition is improving. These nursing homes deny coverage to some Medicare beneficiaries—particularly those with long-term or debilitating conditions and those who need rehabilitation services—based on a so-called “improvement standard.” Prescribed therapy may be reimbursable under Medicare Part A without current progress if progress can be reasonably expected in the foreseeable future or if therapy is necessary to maintain a resident’s...
condition. For more information, visit the Center for Medicare Advocacy, Inc., at www.medicareadvocacy.org.

**Number of Nursing Home Days Covered by Medicare**

Medicare payment for nursing home care does not continue indefinitely. The Medicare program pays for nursing home care for up to only 100 days per benefit period. Additionally, it will pay 100% of the nursing home charges for up to only 20 days, and then daily co-payments are required.

During a resident’s first 20 days in the nursing home, Medicare Part A may pay all of the charges if the resident meets Medicare’s nursing home eligibility requirements. During days 21 through 100 of the resident’s nursing home care, however, the resident must make a daily co-payment before Medicare Part A will pay the remainder of the nursing home charges. As of January 1, 2012, the resident’s daily co-payment for days 21–100 is $144.50. This amount generally increases slightly each year. (For the current co-payment amount, visit Bet Tzedek at www.bettzedek.org/resources.)

Although there is no limit to the number of benefit periods a nursing home resident may have, the resident may receive only up to 100 days of nursing home coverage in any single benefit period. A benefit period begins on the day a resident begins using the hospital or nursing home benefit and ends when the resident has not received any Medicare-covered hospital or nursing home care for 60 days in a row.

For instance, a resident’s benefit period would end 60 days after the resident leaves the nursing home, assuming she has not been readmitted to a hospital or nursing home within that period. After a benefit period ends, the resident must have another three-day qualifying hospital stay and meet Medicare’s eligibility requirements before qualifying for up to another 100 days of nursing home benefits.

**MEDICARE CO-PAYMENTS**

The table below shows the amounts owed by residents and by Medicare as of January 1, 2012 for Medicare-covered nursing home care for the first 20 days, 21–100 days, and more than 100 days. Residents who do not meet the requirements for Medicare coverage may be responsible for paying 100% of their nursing home charges.

<table>
<thead>
<tr>
<th>Days in a Nursing Home</th>
<th>How Much Residents Pay</th>
<th>How Much Medicare Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 to 20</td>
<td>$0</td>
<td>100%</td>
</tr>
<tr>
<td>21 to 100</td>
<td>$144.50 per day</td>
<td>Everything except $144.50 per day</td>
</tr>
<tr>
<td>More than 100</td>
<td>100%</td>
<td>$0</td>
</tr>
</tbody>
</table>
**TIP:** Medicare does not cover all nursing home charges. Medicare may pay in full for nursing home care for days 1–20, but residents may need to make daily co-payments beginning on day 21, and pay the full cost of care starting on day 101.

**Medi-Gap Insurance Policies**
Medi-Gap insurance policies, also called Medicare supplemental policies, pay Medicare deductibles and co-payments. The policies do not pay for additional days of nursing home care. If a resident qualifies for Medicare nursing home coverage during days 21 through 100, a Medi-Gap policy would pay the daily co-payment which is $144.50 as of January 1, 2012. It would not pay for any care after day 100.

**Appealing a Medicare Part A Nursing Home Coverage Decision**
A nursing home makes the initial decision on whether a resident is qualified medically for Medicare Part A payment of nursing home charges. A nursing home that determines that a resident is not qualified for Medicare Part A payment of nursing home expenses must give the resident written notice of its decision.

**TIP:** To qualify for Medicare Part A nursing home benefits, residents and family members should immediately and consistently emphasize the “skilled” services the resident requires and encourage the resident’s physician, nurses, and therapists to do the same.

Residents who disagree with the nursing home’s decision and think they are qualified medically for Medicare Part A payment may appeal the decision. They should begin the appeal by returning the written notice given to them by the nursing home. They should check the box that states: “Option 1. YES. I want to receive these items or services.”

**ASK THE EXPERTS— Medi-Gap Insurance**

*Will a Medi-Gap insurance policy increase my wife’s nursing home benefits under Medicare?*

No, but it may help pay for expenses. Medi-Gap policies, also known as Medicare supplemental policies, are issued by private insurers. Such policies pay Medicare deductibles and co-payments, but do not expand the services covered by Medicare Part A. The only benefit of a Medi-Gap insurance policy for a nursing home resident is to cover the daily co-payment.

Medi-Gap policies do not extend the number of days that Medicare pays for a nursing home stay. If your wife’s nursing home stay qualifies for Medicare coverage, and she has a Medi-Gap insurance policy, the policy will cover her daily co-payment of $144.50 during days 21 through 100, but will not pay for care beyond day 100 of the benefit period.
Residents who disagree with the nursing home’s decision regarding Medicare coverage may appeal.

Subsequent steps in the Medicare Part A appeal process depend upon the particular circumstances of the resident’s case, and are beyond the scope of this guide. Nursing home residents and their families should address specific questions to a knowledgeable Medicare advocate.

Billing for Services During an Appeal
While the Medicare program considers an appeal of a nursing home’s decision, the nursing home cannot require payment from the resident for the disputed nursing home charges. If Medicare eventually agrees with the nursing home and concludes that the resident was not medically qualified for Medicare Part A payment of nursing home charges, the resident can appeal Medicare’s decision through several levels of decision-making. During these subsequent appeals, the nursing home can require payment from the resident for the disputed charges.

Importance of Required Notice
If a nursing home fails to provide a resident with the required written notice, the resident 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 coverage requirements.

Under Medicare law, a nursing home’s failure to provide adequate notice may excuse the resident from paying charges incurred during certain weeks or months. This is especially true if Medicare determines that the resident could not have known that Medicare Part A would not cover the charges incurred during that time period.

Medicare HMOs
Health maintenance organizations, or HMOs, provide health care in return for set monthly fees. HMOs generally require enrollees to receive all of their health care from the HMO. Medicare beneficiaries who are eligible for Medicare Parts A and B may instead choose to receive Medicare Part C (Medicare Advantage) benefits from a Medicare HMO. Medicare HMOs are operated by private

TO LEARN MORE
The California Department of Aging’s Health Insurance Counseling and Advocacy Program (HICAP) provides free personalized counseling for Medicare beneficiaries, including assistance with filing Medicare claims and appeals. To contact HICAP or schedule an appointment with a HICAP Counselor, call (800) 434-0222, or visit their website at www.aging.ca.gov/hicap.

Additional information regarding Medicare Part A appeals is available online from the California Health Advocates at www.cahealthadvocates.org/appeals, “If Your Medicare Part A or Part B Claim is Denied.”
insurance companies and provide health care to Medicare beneficiaries who have signed over their Medicare benefits to the HMO. When beneficiaries sign over their Medicare benefits, the Medicare program pays a set rate each month to the HMO, and the beneficiaries receive all of their Medicare-covered health care from the HMO.

Medicare HMOs provide health care to Medicare beneficiaries who have signed over their Medicare benefits to the HMO.

A Medicare HMO must provide Medicare beneficiaries with at least the services and supplies which Medicare would have provided for them. That means that a Medicare HMO must cover at least 100 days of nursing home care for an HMO enrollee who needs skilled nursing home care as defined by the Medicare program.

Residents enrolled in a Medicare HMO must generally stay in nursing homes authorized by the HMO. To attract enrollees, most Medicare HMOs eliminate the daily copayment ($144.50 as of January 1, 2012) for days 21 through 100 of nursing home care. Some Medicare HMOs increase coverage to 150 days of skilled nursing home care. Claims of expanded coverage may be misleading, however, because Medicare HMOs may refuse to authorize nursing home care. Although an enrollee may be entitled to up to 150 days of nursing home care, the HMO may stop payment after a few days, claiming that the resident no longer meets the Medicare criteria for nursing home coverage.

Can my sister’s Medicare HMO force her to leave her nursing home?

No, it cannot. Medicare HMOs make decisions only about the services for which they will pay. If the nursing home wants your sister to leave because the HMO is no longer paying for her care, the nursing home must follow federal and California transfer and discharge requirements. Payment decisions do not give HMOs authority to force a resident to leave a nursing home. (For more information, see Chapter 5, pages 70–73.)

Appealing a Medicare HMO’s Refusal to Pay for Nursing Home Care

When a Medicare HMO denies or terminates nursing home coverage, residents have the following appeal options: standard appeal; expedited appeal; or fast-track appeal. This guide recommends requesting a fast-track appeal in all instances. Standard and expedited appeals take longer to resolve than fast-track appeals, and are reviewed by the Medicare HMO which made the initial decision to deny or terminate coverage. Fast-track appeals must be processed within
48 hours, and are reviewed by an outside organization instead of the Medicare HMO. 

This guide recommends requesting a fast-track appeal in all instances.

Fast-Track Appeals
In California, fast-track appeals are reviewed by the Health Services Advisory Group, www.hsag.com, (800) 841-1602. To request a fast-track appeal, residents should follow the instructions on the Medicare HMO’s notice of non-coverage.

If the Medicare HMO is denying nursing home coverage entirely, the HMO must give the resident written notice at the time of admission to the nursing home. If the Medicare HMO is terminating existing coverage, it must give notice at least two days before the proposed date of termination.

ASK THE EXPERTS—SWITCHING FROM MEDICARE HMO TO MEDICARE

I signed my Medicare benefits over to a Medicare HMO, and am not happy with their services. I recently moved into a nursing home. Can I switch back to traditional (fee-for-service) Medicare?

Yes, you can. Nursing home residents may cancel, or disenroll from, their Medicare HMO and return to the Medicare program by submitting a written request for disenrollment to either the Medicare HMO or the local Social Security office. Disenrollments generally become effective on the first day of the next month. Medicare HMO enrollees who do not live in nursing homes are subject to a lock-in period and typically can change or leave a Medicare HMO only once per year.

The notice must include the date that the resident’s coverage is scheduled to end and instructions on how to appeal. The resident should request the appeal as soon as possible, and no later than noon on the day before the resident’s coverage is scheduled to terminate.
The Health Services Advisory Group is required to rule on fast-track appeals within 48 hours. For residents who win an appeal, the Medicare HMO will pay for their nursing home care. Residents who lose an appeal will be responsible for the cost of their care starting the day the Health Services Advisory Group issues its decision. If the resident fails to pay, the nursing home may be able to transfer or discharge the resident for non-payment. (For more information, see Chapter 5, pages 70–73.)

**Medi-Cal**

The Medicaid program, referred to in California as Medi-Cal, is a program provided by California and the federal government to pay for medical expenses for individuals with little or no money. Medi-Cal recipients may also be enrolled in Medicare, but the two programs are not related. The Medi-Cal program is a needs-based program, and has very strict eligibility requirements.

For qualified individuals, Medi-Cal will pay for all nursing home costs regardless of length of stay. In contrast to Medicare, Medi-Cal does not place restrictive medical requirements for coverage of nursing home care. Medi-Cal will pay for a resident to receive non-skilled (custodial) care as long as the services are “medically necessary.” In addition, unlike the Medicare program, Medi-Cal will pay for an unlimited number of days of nursing home care.

**Medi-Cal Eligibility**

The eligibility requirements for Medi-Cal coverage of nursing home care differ from those for Medi-Cal coverage of individuals not in a nursing home. This guide discusses only Medi-Cal coverage for nursing home care.

Nursing home residents are eligible for Medi-Cal coverage if they are at least 65 years old or disabled and if they meet certain income and resource limits.

**TIP:** Medi-Cal eligibility can be granted retroactively up to three months before the month of application if the applicant meets the Medi-Cal eligibility standards during those months.

**Medi-Cal Income Rules and Limits**

In California, there are no income limits for Medi-Cal eligibility for an unmarried nursing home resident. However, an unmarried resident may keep only $35 of her monthly income. The $35 is considered the resident’s “personal needs allowance.” The remainder of the resident’s monthly income must be used to pay her current and past medical bills, health insurance premiums, and nursing home charges. The Medi-Cal program then will pay the balance of the nursing home charges.

For a married couple in which one of the spouses is a nursing home resident, the at-home spouse is allowed to keep a monthly income of at least her individual monthly income, or $2,841 (rate effective as of January 1, 2012) from the couple’s joint income, whichever is greater. The Medi-Cal program will pay the balance of the nursing home charges.

---

1. The resource and income amounts quoted in this section will become effective January 1, 2012, and may be increased slightly at the beginning of subsequent years. For current rates, visit Bet Tzedek at www.bettzedek.org/resources.
refers to the amount of money it allows at-home spouses to keep as the Minimum Monthly Maintenance Needs Allowance, or MMMNA. The MMMNA rate generally increases slightly each year. (For current MMMNA rates, visit Bet Tzedek at www.bettzedek.org/resources.)

The married nursing home resident, like the unmarried nursing home resident, is entitled to keep only $35 of her monthly income as a personal needs allowance. The remainder of the married nursing home resident’s monthly income (after deductions for the MMMNA and personal needs allowance) must be used to pay the resident’s current and past medical bills, health insurance premiums, and nursing home charges. Medi-Cal will then pay the balance of the nursing home charges.

**Maintenance Allowance for Home or Apartment**

A resident may be able to keep additional income to help pay for her home or apartment while she lives in a nursing home if the resident’s physician certifies that she is likely to need nursing home care for no more than six months. This “extra” income allocation is small, just $209 per month as of January 1, 2012—generally not enough to maintain an apartment or home. However, the allocation may at least help to offset some expenses. (For the current maintenance allowance amount, visit Bet Tzedek at www.bettzedek.org/resources.)

**TIP:** Medi-Cal pays only for health care expenses and will not pay for items such as clothing, even if a resident has no income or savings. However, nursing home residents with very limited income and resources may be eligible for Supplemental Security Income (SSI), a program administered by the Social Security Administration. SSI can supplement income up to $50 per month for qualified residents. For more information about SSI, call Social Security at (800) 772-1213 or visit www.socialsecurity.gov/ssi.

**Medi-Cal Resource Rules and Limits**

Eligibility for Medi-Cal nursing home coverage depends on the value of resources or assets that the resident owns, but not all assets are counted. Medi-Cal classifies assets as “exempt” and “non-exempt.” Exempt assets are not counted in determining Medi-Cal eligibility; non-exempt assets are counted.
(The classification of assets as exempt and non-exempt is discussed below. In general, a house is considered an exempt asset.)

Medi-Cal resource limits differ depending on the marital status of the nursing home resident. The Medi-Cal program generally requires that unmarried residents spend virtually all of their available resources to qualify for Medi-Cal payment of nursing home care. However, the program does not require that healthy spouses impoverish themselves to pay for their spouses’ nursing home care.

Eligibility for Medi-Cal nursing home coverage depends on the value of resources or assets that the nursing home resident owns, but not all assets are counted.

Resource Limits
An unmarried person is eligible for Medi-Cal payment of her nursing home care if she has non-exempt assets valued at $2,000 or less.

While the Medi-Cal program requires that an unmarried nursing home resident have non-exempt assets valued at $2,000 or less to qualify for Medi-Cal coverage, it allows the spouse of a married nursing home resident to keep additional assets and income (assuming that the spouse does not also live in the nursing home). Medi-Cal refers to the amount of assets an at-home spouse can keep as the Community Spouse Resource Allowance, or CSRA. The CSRA will be $113,640 as of January 1, 2012. (For current CSRA rates, visit Bet Tzedek at www.bettzedek.org/resources.)

An unmarried person is eligible for Medi-Cal payment of her nursing home care if she has non-exempt assets valued at $2,000 or less. Medi-Cal allows the spouse of a married nursing home resident to keep additional assets and income.

In 2012, couples composed of a nursing home resident and an “at-home” spouse are eligible for Medi-Cal payment of nursing home care if the couple’s non-exempt assets total $115,640 or less. Here is that formula:

\[
113,640 + 2,000 = 115,640
\]

(TIP: If Medi-Cal is paying for your spouse’s nursing home care and you are having trouble making ends meet, consider requesting a court hearing to increase the amount of income and assets you can keep.)
CASE STUDY: THE SMITHS

This case study uses a make-believe family, the Smiths, to help explain Medi-Cal eligibility rules. It shows the Smiths in three different situations to demonstrate how changes in a family’s income and resources can impact how much they have to pay for nursing home care.

Remember, whenever questions arise about such matters, check with an attorney knowledgeable in Medi-Cal planning.

Background
Mr. Smith has just moved into a nursing home. His wife, Mrs. Smith, lives in the couple’s home in Sacramento.

Situation #1
The Smiths have savings of $50,000 in a bank account. Mr. Smith receives $2,000 per month from the Social Security Administration, and Mrs. Smith receives a $1,000 monthly pension.

The Smiths’ home is considered an exempt asset, since Mrs. Smith lives there. The Smiths’ available resources total $50,000, which is less than the current (2012) Medi-Cal Community Spouse Resource Allowance (CSRA) limit of $113,640, so Mr. Smith is eligible for Medi-Cal payment of his nursing home care.

The Smiths’ joint income totals $3,000. Mrs. Smith is entitled to an allowance of $2,841 monthly, the current (2012) Minimum Monthly Maintenance Needs Allowance (MMMNA). Mr. Smith is entitled to a personal needs allowance of $35.

Together the Smiths have a joint allowance of $2,876 ($2,841 MMMNA + $35 personal needs allowance). Each month, Mr. Smith must pay the nursing home a total of $124 as his “share of cost.” Here is the equation for that calculation:

$$
\frac{\text{total income}}{\text{joint allowance}} = \frac{3,000}{2,876} = 124
$$

Situation #2
Assume now that Mr. Smith’s income is $1,000 per month. Assume also that the couple’s joint income totals $2,000.

As in Situation #1, the Smiths have a joint allowance of $2,876 ($2,841 MMMNA + $35 personal needs allowance). However, unlike Situation #1, Mr. Smith will not have to pay any share of cost to the nursing home because the Smiths’ joint income of $2,000 is less than their joint allowance of $2,876.

Mr. Smith is entitled to keep $35 of the couple’s total monthly income as his personal needs allowance, and Mrs. Smith is entitled to keep the balance of $1,965.

Situation #3
Finally, assume that the Smiths have savings of $360,000. Assume further that Mr. Smith receives a monthly Social Security payment of $1,000 and that Mrs. Smith receives a monthly pension of $1,000. Their joint
CASE STUDY: THE SMITHS CONTINUED

income in this instance equals $2,000.

At first glance, Mr. Smith seems ineligible for Medi-Cal because the couple’s joint savings of $360,000 exceeds the Medi-Cal program’s CSRA limit of $113,640. However, because the Smiths’ joint income of $2,000 is less than the couple’s joint income allowance of $2,876, the Smiths could seek a court order to increase their resource allowance to a total of $360,000 and thereby retain all of their savings.

The Smiths ability to keep all of their savings depends on certain assumptions. Assume that the couple’s $360,000 in savings earns a 2% simple interest rate. Their account would produce $7,200 in interest each year, or $600 each month. That puts the Smiths’ total monthly income at $2,600. Here is the equation for that calculation:

$1,000 + $1,000 + $600 = $2,600
(Mr. Smith's SSA payment) (Mrs. Smith's pension) (interest)

Because the Smiths’ total monthly income of $2,600 (including interest income from their savings) is less than the $2,876 allowance for the couple ($2,841 MMMNA for Mrs. Smith + $35 personal needs allowance for Mr. Smith), Mr. Smith is eligible for Medi-Cal payment of his nursing home care if the Smiths obtain a court order to increase their resource allowance to a total of $360,000.

Since the Smiths’ joint income of $2,600 is less than their joint allowance of $2,876, they would not have to pay any share of cost to the nursing home. Mr. Smith would be entitled to keep $35 of the couple’s total monthly income as his personal needs allowance, and Mrs. Smith would be entitled to keep the balance of $2,565 ($2,600 total monthly income – $35 personal needs allowance).

Court Order to Increase Income or Resource Allowance
Under certain circumstances, an at-home spouse can obtain an order from a court or an administrative law judge to allow the at-home spouse to keep more assets or income than normally allowed. Such an order can allow the couple to retain more than the 2012 CSRA of $113,640 in non-exempt assets as long as the income that could be generated by the retained assets would not cause the total monthly income available to the at-home spouse to exceed the 2012 MMMNA of $2,841. A court order also can allow the at-home spouse to retain more than the MMMNA of $2,841 in monthly income.

Exempt and Non-Exempt Assets
The Medi-Cal program covers only individuals or couples with limited resources, or assets. Assets include such items as money, bank accounts, real estate, investments, automobiles, household goods, and personal effects. However, the Medi-Cal program does
not count all assets in determining eligibility.

Medi-Cal classifies assets as either exempt or non-exempt. Exempt assets are not counted in determining eligibility, and non-exempt assets are counted. Nursing home residents may have an unlimited number of exempt assets and still be eligible for Medi-Cal, but they must keep the value of their non-exempt assets at or below the Medi-Cal resource limit of $2,000.

Residents, prospective residents, and family members should understand that Medi-Cal’s eligibility rules and regulations are complex. A detailed discussion of the program’s classification of assets is beyond the scope of this guide, so contact a knowledgeable attorney to discuss specific circumstances. Here are some general guidelines for exempt and non-exempt items.

**Exempt.** Medi-Cal generally considers exempt the value of the following items:

- House used as a primary residence
- Household goods
- Personal effects
- One automobile
- Term life insurance
- Burial plot
- Prepaid irrevocable burial plan
- Business property

**Non-exempt.** Medi-Cal generally considers non-exempt (meaning that they will be counted against the Medi-Cal resource limit of $2,000) the value of these items:

- Cash
- Bank accounts
- Stocks
- Investments
- Rental property
- Vacation homes

**Other assets.** The classification of various other assets as exempt or non-exempt depends on the circumstances. For example, the cash surrender value of a whole life insurance policy is considered exempt only if its face value is $1,500 or less. A designated burial fund of $1,500 or less is considered exempt, as is accumulated interest on the burial funds.

Work-related pensions and retirement accounts such as IRAs are considered exempt if owned in the name of the resident’s spouse. If the pensions and retirement accounts are owned in the resident’s name, they are considered exempt 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 would be included in the calculation of the resident’s share of cost.

**TIP:** When the Medi-Cal eligibility of a married nursing home resident is established, the couple must allocate their resources between themselves so that no more than $2,000 in non-exempt assets is held in the resident’s name. As soon as that allocation is complete, the resident becomes eligible for Medi-Cal and retains that eligibility as long as the resident’s non-exempt assets don’t exceed $2,000, regardless of the amount of the at-home spouse’s non-exempt assets.

**Medi-Cal Treatment of a Resident’s House**

Medi-Cal considers a resident’s house exempt if the resident intends to return home following the resident’s nursing home stay. The Medi-Cal application asks the resident if she intends to return to her house. If she answers “Yes,” the Medi-Cal program will not count the value of the house against the resource limit, even if the resident is unlikely ever to return home.

If the Medi-Cal applicant is mentally incapacitated, a family member may declare an applicant’s intent to return home. This question on the Medi-Cal application could be rephrased as, “If the resident were completely healthy, would she live in her home?” If the answer to that question is “Yes,” the answer on the Medi-Cal application also should be yes. Even if the question was originally answered “No,” the

---

**ASK THE EXPERTS—A RESIDENT’S HOUSE IS EXEMPT**

*My father had a massive stroke last month and most likely will have to live in a nursing home for the rest of his life. My mother died three years ago, so my father owns the family home all by himself. Other than the home, he has only about $800 in savings. I have legal authority to make financial decisions for my father. Do I have to sell my father’s home before he can be eligible for Medi-Cal?*

No, you do not. Your father is eligible for Medi-Cal now, assuming that his Medi-Cal application is filled out correctly, because Medi-Cal will consider his house as an exempt asset. On your father’s Medi-Cal application, make sure that you or he indicate that he intends to return to his house by answering “Yes” to the question about returning home. You can assume that your father would want to return to that house if his condition were to improve. Since his house is considered exempt and his non-exempt assets ($800 in savings) are less than the Medi-Cal resource limit of $2,000, Medi-Cal will pay for his nursing home care.

Medi-Cal program allows the answer to be changed to “Yes” at any time.

A resident’s house is also considered an exempt asset if the resident’s spouse, child
under 21, or “dependent relative” lives in the house, or if the resident’s adult child, brother, or sister (1) lives in the house and (2) began living in the house at least one year before the resident entered the nursing home. The house also may be considered an exempt asset if there are legal obstacles preventing the sale of the house or the house is a multiple dwelling unit, and one of the units is the principal residence of the nursing home resident.

**TIP:** Nursing home residents should generally not sell their house to pay for nursing home care. Such a sale converts an exempt asset (the house) into a non-exempt asset (cash), which will likely make the resident ineligible for Medi-Cal for an extended period of time.

Medi-Cal generally cannot impose a lien on a resident’s house during the resident’s lifetime. Medi-Cal can assess a lien during the resident’s lifetime only if a resident has stated that she does not intend to return to her home and if she has listed the house for sale but it has not yet been sold.

**Medi-Cal generally cannot impose a lien on a resident’s home during the resident’s lifetime.**

Changes in federal and state laws can impact Medi-Cal eligibility requirements. Most experts—including Bet Tzedek—strongly recommend that nursing home residents consult with an attorney experienced in Medi-Cal planning before selling or transferring title to their house.

‘Spending Down’ and Converting Assets

Nursing home residents who are not eligible for Medi-Cal because they have more than $2,000 in non-exempt assets can bring the value of their countable assets within the Medi-Cal resource limit by “spending down,” or by converting non-exempt assets into exempt assets.

A resident may spend down non-exempt assets such as cash on any activity, service, or item that benefits the resident. For example, a resident could reduce her non-exempt resources by paying bills, remodeling or repairing her house, or paying off a mortgage, car loan, or other debts.

For many nursing home residents, assets are spent down by paying for their nursing home care. Private-pay residents may have more options when looking for a nursing home. Many residents begin their stay at a Medi-Cal certified nursing home as privately-paying residents, and then become eligible for Medi-Cal after spending down their savings to $2,000 (or less) on nursing home care.

Residents may also reduce their resources to a level that falls under Medi-Cal’s $2,000 limit by converting non-exempt assets into exempt assets. For example, a resident could use her savings above $2,000 to purchase term life insurance, a burial plot, or medical equipment such as hearing aids, dentures, walkers, or wheelchairs.
Nursing home residents may reduce their resources to a level that falls under Medi-Cal’s $2,000 limit by purchasing medical equipment, term life insurance, or a burial plot.

Giving Away Assets
Nursing home residents may give away assets to become eligible for Medi-Cal, but doing so may delay their eligibility. Under certain circumstances, the Medi-Cal program will penalize nursing home residents who give away assets to become eligible for Medi-Cal by delaying their eligibility for the period of time the assets could have paid for nursing home care.

The laws regarding the transfer of assets are complicated. California is in the process of changing its Medi-Cal eligibility rules, including rules about transfer of assets and time periods of ineligibility. Nursing home residents should not give away assets to accelerate Medi-Cal eligibility without first talking to a knowledgeable attorney.

Nursing home residents may give away assets to become eligible for Medi-Cal, but doing so may delay their eligibility.

Medi-Cal Estate Claims
After a nursing home resident’s death, Medi-Cal may make a claim against the resident’s estate to repay the cost of benefits paid on behalf of the resident. However, Medi-Cal’s claim is limited to the amount paid by Medi-Cal on behalf of the beneficiary or the value of the beneficiary’s estate, whichever is less.

Medi-Cal cannot make a claim against a resident’s estate if the resident is survived by a spouse, minor child, or child who is disabled under the standards of the Social Security Administration. Medi-Cal may waive estate claims if a resident’s heirs show that enforcement of the claim would cause them to suffer substantial hardship.

Laws pertaining to Medi-Cal estate claims are complicated and change frequently, so nursing home residents and their families should address specific questions to a knowledgeable attorney.

TO LEARN MORE

Long-Term Care Insurance
Long-term care insurance policies are designed to pay or reimburse individuals for long-term care expenses. A person considering long-term care insurance should carefully examine proposed insurance policies and take into account factors such as age, health, financial
situation, and attitude toward Medi-Cal coverage. A person who is considering long-term care insurance should calculate what level of financial loss is unacceptable and consider purchasing insurance to prevent that loss.

Look for long-term care policies that cover many types of long-term care, including home care and care provided in an assisted living facility or nursing home. Policies should also limit premium increases and contain a provision that will increase benefit levels if the costs of long-term care increase.

**Long-term care policies should cover many types of long-term care, including home care and care provided in an assisted living facility or nursing home.**

Under California law, insurance policies covering nursing home care cannot deny coverage to residents suffering from Alzheimer’s disease or other degenerative brain disorders unless the denial is based on the resident’s failure to disclose the disorder to the insurance company when applying for the policy.

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

Generally, individuals should not purchase long-term care insurance if they are eligible now or soon will become eligible for Medi-Cal reimbursement, because the Medi-Cal program will cover the cost of their nursing home care.

**TIP:** Long-term care insurance policies always allow the insurer to increase premiums. Do not purchase a policy unless you can easily handle the premiums.

**CLASS Act**

The federal government passed a law in 2010 known as the *Community Living Assistance Services and Supports Act* or CLASS Act. This act creates a voluntary program under which individuals pay a monthly premium, and are eligible for modest benefits for their long-term care needs after five years of paying premiums.

Due to concerns about its financial viability, the CLASS Act program may not be implemented. If the CLASS Act remains in effect, it may help more people pay for long-term care. For updates on the CLASS Act, visit Bet Tzedek at [www.bettzedek.org/resources](http://www.bettzedek.org/resources).
RESOURCES
For more information on topics in this chapter, consult the following agencies, print and online resources, and the legal citations on which the information is based.

Agencies
• Bet Tzedek Legal Services: www.bettzedek.org, (323) 939-0506
• California Advocates for Nursing Home Reform: www.canhr.org, (800) 474-1116
• California Department of Aging, Health Insurance Counseling and Advocacy Program (HICAP): www.aging.ca.gov/hicap, (800) 434-0222
• California Long-Term Care Ombudsman Program: www.aging.ca.gov/programs (search: “ombudsman”), CRISISline (800) 231-4024. (For phone numbers of local Ombudsman Programs, see Appendix B, pages 115–117.)
• Center for Medicare Advocacy, Inc.: www.medicareadvocacy.org, (860) 456-7790
• Health Services Advisory Group: www.hsag.com, (800) 841-1602

Print

Online
• Administration on Aging: www.aoa.gov (search: “CLASS”)
• California Advocates for Nursing Home Reform Fact Sheet, “Overview of Medi-Cal for Long-Term Care”: www.canhr.org/factsheets
• California Department of Health Care Services, “Estate Recovery Program Pamphlet”: www.dhcs.ca.gov (search: “estate recovery program”), (916) 650-0490
• California Department of Insurance: www.insurance.ca.gov (search: “long term care insurance”), (800) 927-HELP (4357)

• California Health Advocates, “If Your Medicare Part A or Part B Claim Is Denied”: www.cahealthadvocates.org/appeals

• California Health Advocates, “If Your Medicare Part C (Medicare Advantage) Claim is Denied”: www.cahealthadvocates.org/appeals

• California Partnership for Long-Term Care: www.dhcs.ca.gov (search: “Partnership for Long Term Care”), (916) 552-8990

• Centers for Medicare & Medicaid Services (CMS): www.medicare.gov (search: “appeals”)

• Medicare Rights Center: www.medicareinteractive.org (search: “appeals”)

• National Center for Lesbian Rights, “Planning with Purpose: Legal Basics for LGBT Elders”: www.nclrights.org (search: “planning with purpose”)

• Social Security Administration: www.socialsecurity.gov/ssi , (800) 772-1213

Legal Citations
The discussions in this chapter are based primarily on Title 42 of the United States Code, sections 426, 1395c, 1395d, 1395f, 1395k, 1396p and 1396r-5; Title 42 of the Code of Federal Regulations, sections 409.30 through 409.36, 409.60, 483.12(a); California Health and Safety Code, sections 1320 and 1599.67(a); California Insurance Code, sections 10231 through 10237.6; California Welfare and Institutions Code, sections 11158, 14006, 14006.7, 14009.5, 14110.4, 14134.6, and 22000 through 22010; 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; California Department of Health Services All County Welfare Director’s Letters 86-33, 89-54, 90-01, 90-03, 90-11, 91-28, 95-22, 95-48, 11-04, 11-08, 11-13, and 11-16; Hunt v. Kizer (E.D. Cal. 1989); Johnson v. Rank (N.D. Cal. 1986); Sarrassat v. Sullivan, 1989 WL 208444 (N.D. Cal. 1989); Medicare Skilled Nursing Facility Manual, sections 357 and 358.
CHAPTER 3
ADMISSION TO A NURSING HOME
ADMISSION TO A NURSING HOME

Nursing home admissions often occur during stressful times for a resident and family members. As a result, residents often are inclined to agree to whatever conditions the nursing home sets in its admission agreement.

Resist this inclination.

Some nursing homes request illegal or unfair conditions that, if accepted, could lead to serious problems in the future. Federal and state laws provide many protections to nursing home residents during the admission process. This chapter describes the rights of nursing home residents in connection with admission, including admission decisions, admission agreements, payment provisions, and other common problems with admission agreements.

Know Your Rights
If you have questions or concerns about the admission process or the admission agreement, discuss them with nursing home staff. Although nursing homes are required to comply with the laws discussed in this guide, they do not always do so.

A resident and family members can help make sure that the resident receives quality care by raising concerns at the earliest opportunity. After reading this guide, you may have a better understanding of nursing home laws than the average nursing home staff member.

If you see something inconsistent with what you have read here, question it. Explain that your understanding of what the law requires differs from theirs. Assert your rights.

CALIFORNIA STANDARD ADMISSION AGREEMENT ON HOLD

In 1997, California passed a law requiring nursing homes to use a standard admission agreement, a form to be developed by the California Department of Public Health (CDPH). After many years, the CDPH established a Standard Admission Agreement and in January 2006 began requiring nursing homes to use it.

In early 2006, a group of nursing home owners sued to invalidate the agreement. The court temporarily suspended its use. The CDPH is currently revising its Standard Admission Agreement to comply with the court order, and has stated that it will require nursing homes to begin using the revised agreement on or before April 6, 2012. For updates on the Standard Admission Agreement, visit Bet Tzedek at www.bettzedek.org/resources.

Until the CDPH reissues the Standard Admission Agreement, nursing homes are free to use their own admission agreements, some of which may contain misleading or illegal provisions.

If you have questions or concerns about the admission process or the admission agreement, discuss them with nursing home staff.
Admission Decisions
In general, nursing homes can accept or reject any particular applicant. Applicants who are rejected by a nursing home may not learn the reason for their rejection. Nursing homes are not required to give a reason for their rejection decisions. However, nursing homes cannot reject an applicant based on an unlawful reason.

Unlawful reasons for rejection include discrimination against applicants based on national origin, race, color, or difficult care needs. Applicants who believe they have been denied admission based on an unlawful reason should contact a knowledgeable attorney.

*Nursing homes cannot reject an applicant based on an unlawful reason.*

Admission Agreements
Prospective residents who are accepted for admission will need to sign an admission agreement. California does not currently require nursing homes to use a standard admission agreement. As a result, the specifics of the agreement may vary from nursing home to nursing home.

California law requires nursing homes to make blank copies of their admission agreements available to the public at cost. Before making an admission decision, residents considering a particular nursing home should obtain a copy of that agreement and take as much time as needed to review it. Residents should ask the nursing home to explain terms or provisions they do not understand and to delete provisions that seem

---

**ASK THE EXPERTS—WAITING TO SIGN AN ADMISSION AGREEMENT**

The nursing home wants my father to sign its admission agreement before he enters, but we both need more time to review the document. Can we wait to sign the agreement?

Yes. Nursing home residents are not required to sign admission agreements prior to being admitted to a nursing home. Nursing homes may be reluctant to admit a resident who expresses concerns about the admission agreement prior to admission. However, residents who wait until after admission to review the agreement will have more time to analyze it and cannot be penalized for requesting changes.

Although a nursing home could refuse to admit an applicant who requests changes to an admission agreement, it cannot evict a resident, accepted for admission, who does the same thing. As a result, residents have the most leverage for obtaining changes to the agreement after they are admitted to the nursing home.

You and your father should take as much time as you need to review the agreement, and it can be signed after your father has been admitted to the nursing home.
unfair or illegal. Residents should not allow nursing home staff to pressure them into signing the admission agreement before they are ready to do so.

**Payment Provisions**

Some admission agreements adequately describe nursing home charges, but others do not. The law requires that admission agreements describe the services available at the facility and the costs associated with those services.

Agreements must clearly state which services and supplies are covered by the nursing home’s basic daily rate, Medi-Cal, and Medicare, and which services and supplies are optional, as well as the cost of those options. Optional and covered services may be different depending on whether a resident’s care is being paid for privately or by Medi-Cal or Medicare. When a resident converts from private pay or Medicare to Medi-Cal, the nursing home must give the resident a list of Medi-Cal covered and optional services.

*Agreements must clearly state which services and supplies are covered by the nursing home’s basic daily rate, Medi-Cal, and Medicare.*

**Monthly Statements and Itemized Charges**

The admission agreement must state that residents will receive monthly statements listing all charges incurred by them. The nursing home must provide at least 30 days written notice to a resident of any increase in the daily room rate or charges for optional services.

**Medi-Cal Participation and Eligibility**

Nursing home residents may be eligible for Medi-Cal payment of their nursing home charges. (For more information, see Chapter 2, pages 28–36.) Every admission agreement must clearly state whether the facility participates in the Medi-Cal program.

Prior to admission, Medi-Cal-certified nursing homes must provide residents with a written statement regarding Medi-Cal’s eligibility standards. The statement must explain the income and resource requirements of Medi-Cal, including which assets are exempt, protections for married couples, and a resident’s right to transfer his home.
Every admission agreement must clearly state whether the facility participates in the Medi-Cal program.

PAYMENT BY MEDI-CAL OR MEDICARE
Prospective residents and family members should keep these key points of law in mind:

• It is illegal for a Medi-Cal- or Medicare–certified nursing home to require a resident who is eligible for Medi-Cal or Medicare payment of nursing home charges to pay privately for any period of time.

• Nursing homes cannot require that residents certify that they are not eligible for Medi-Cal or Medicare nursing home benefits.

• Nursing homes cannot require that residents promise they will not become eligible for Medi-Cal or Medicare benefits in the future.

• When residents qualify for Medi-Cal or Medicare nursing home coverage, nursing homes certified by these programs must accept their payments.

Financial Guarantees and “Responsible Party” Agreements
Many nursing homes try to get a resident’s family or friends to accept personal financial responsibility for the resident’s nursing home charges. Federal law prohibits a nursing home from requiring a third-party guarantee of payment as a condition of a resident’s admission. Your sister is the only person whose funds must be used to pay the nursing home. You cannot be required to guarantee her payments to the nursing home.

ASK THE EXPERTS—GUARANTEEING A RESIDENT’S PAYMENT
My sister was just admitted to a nursing home. I’m her only living relative, so the nursing home has asked me to accept personal financial responsibility for her nursing home charges. I’m on a fixed income myself and am not comfortable taking on her debts as well. Can they make me accept financial responsibility for my sister’s care?

No, they cannot. Many nursing homes try to get the resident’s family or friends to accept personal financial responsibility for the resident’s nursing home charges. Federal law prohibits a nursing home from requiring a third-party guarantee of payment as a condition of a resident’s admission. Your sister is the only person whose funds must be used to pay the nursing home. You cannot be required to guarantee her payments to the nursing home.
guarantor cannot be required, but then they claim that any person can voluntarily 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.

**Beware the Signature Line**

Residents and their family members or friends should beware of signature lines called “Responsible Party.” These signature lines do not define the term “responsible party,” but may refer to an earlier paragraph defining a responsible party as a person financially liable for the resident’s nursing home charges.

Even if individuals have signed agreements as financially responsible parties, they should not assume that they are financially responsible for the resident’s nursing home bills. These voluntary promises to pay are unenforceable, because the nursing home promised nothing in return for the financial guarantee. In addition, these voluntary guarantees are unenforceable because they are grossly unfair, or in legal terms, unconscionable.

**Avoiding the Responsible Party Trap**

To avoid becoming a “responsible party,” never sign an agreement as a responsible party, guarantor, financial agent, or any other term used in the admission agreement as a person who personally guarantees payment of nursing home fees. If you manage a Medi-Cal beneficiary’s finances, cross out improper terms and replace them with agent (not financial agent). If you are the resident’s legal representative, such as a conservator, cross out improper terms and replace them with your legal role.

---

**ASK THE EXPERTS—SIGNING AS THE RESPONSIBLE PARTY**

The nursing home won’t admit my mother unless I sign an admission agreement as “responsible party.” What should I do?

Do not sign anything as “responsible party.” Under federal law, the nursing home cannot require you to become personally liable for your mother’s nursing home charges. By requiring you to sign as “responsible party,” the nursing home is breaking the law.

But if I don’t sign as a “responsible party” and my mother becomes unable to pay the nursing home fees, she’ll have to leave. I’m willing to pay her nursing home charges, if necessary.

The law generally requires nursing homes to give a 30-day notice to transfer or discharge a resident. If your mother can no longer pay for her care, you will have the opportunity to step in and make payments to prevent her discharge. This can all be done without signing as the responsible party.
Payments by Authorized Representatives
Nursing homes may require a resident’s authorized representative to use the resident’s money to pay for nursing home charges. Authorized representatives include the following:
- Conservators
- Medi-Cal representatives
- Representative payees for Social Security benefits
- Agents acting under a financial power of attorney

Be aware that a nursing home cannot require an authorized representative to guarantee a resident’s payments with the representative’s own money.

Deposits
Nursing homes cannot require deposits from a resident if either Medi-Cal or Medicare is paying for the resident’s stay. However, nursing homes may require a deposit from residents who pay for their stay without assistance from those programs.

Refunds After Death or Discharge of Resident
Admission agreements cannot require residents to pay for days of stay beyond the date of an involuntary discharge or the resident’s death. Nor may agreements require residents to give advance notice of their discharge date. Any resident can leave a nursing home anytime without giving advance notice to the nursing home. However, if residents voluntarily leave the facility within three days of admission, nursing homes may charge them for up to a maximum of three days at the basic daily rate.
Any resident can leave a nursing home anytime without giving advance notice to the nursing home.

Common Problems with Admission Agreements
The admission agreement is a legally binding document that states the responsibilities of the nursing home and the resident. Admission agreements vary widely from nursing home to nursing home, and some contain misleading, incorrect, or illegal provisions. This section discusses some common problems in nursing home admission agreements, together with the federal and California laws that address these problems.

TIP: Before signing the admission agreement, a resident should read and study it carefully to make sure that he understands all of its terms, get answers to any questions he may have concerning the admission agreement, and make sure that confusing, unfair, or illegal provisions have been changed.

Arbitration Agreements
Arbitration is a dispute resolution process in which an individual, called an arbitrator, decides whether a resident is entitled to compensation. Judges and juries are not involved. If a resident agrees to binding arbitration, the arbitrator’s decision is final and cannot be appealed.

ASK THE EXPERTS—HANDLING ILLEGAL OR UNFAIR PROVISIONS
I think the admission agreement my grandfather has been asked to sign contains illegal or unfair provisions. What should I do?

Discuss your concerns with the nursing home and negotiate changes. If the nursing home agrees to the changes, mark them on the admission agreement. Ask the nursing home representative to place his initials next to the changes. Make sure that you obtain a signed copy of the revised agreement.

Here are other options to consider:

- Contact the Long-Term Care Ombudsman Program or Bet Tzedek for assistance.
- File a complaint with the California Department of Public Health.
- Refuse to sign the admission agreement. Remember, nursing homes may not transfer or discharge a resident because he refuses to sign an admission agreement.

Phone numbers for the local Ombudsman Program and the Department of Public Health are listed in Appendices B and C, pages 115–120.
If a resident agrees to binding arbitration, the arbitrator’s decision is final and cannot be appealed.

Some nursing homes require residents to sign arbitration agreements as a condition of admission. That is illegal. Nursing homes cannot require that a resident agree to arbitration. The nursing home may include an arbitration agreement in its admission documents, but the arbitration agreement must be on a separate form, not part of the admission agreement, and the admission agreement must clearly state that agreeing to arbitration is not a precondition for medical treatment or admission.

TIP: This guide recommends that residents do not sign arbitration agreements at admission. Arbitration has advantages and disadvantages, and a decision to arbitrate should be made only after consultation with an attorney. If arbitration is the best option, residents can make that choice after a dispute has arisen. They do not need to give up their rights in advance.

Complaint and Grievance Policies
Problems in a nursing home can be handled in several ways. (For more information, see Chapter 8, pages 104–109.) Admission agreements must notify residents that a copy of the nursing home’s grievance procedures is available. The agreement must also inform residents of the right to contact the California Department of Public Health or the Long-Term Care Ombudsman Program if they want to file a complaint against the nursing home.

TIP: Make sure you obtain a copy of the signed admission agreement.

Confidentiality of Medical Information
Some admission agreements fail to inform residents of their right to limit access to their medical information. An admission agreement must state that residents have a right to confidential treatment of medical information and provide a means by which residents may authorize disclosure of that information to individuals of their choice.

Consent to Medical Treatment
Some admission agreements require a resident to consent to all treatments recommended by the nursing home or its physicians. However, admission agreements legally can request consent only for routine nursing care or emergency care. A resident always retains the right to refuse any type of medical treatment, no matter what it states in the admission agreement.

The resident always retains the right to refuse any type of medical treatment, no matter what it states in the admission agreement.

Personal Property
Nursing homes are required to protect the personal property of all residents. (For more
At admission, nursing homes must give residents a copy of their policies and procedures dealing with the protection of personal property. They must also establish a personal property inventory for each resident and give a copy to the resident or his personal representative.

Residents may request that nursing homes hold their personal funds, but nursing homes cannot require residents to allow them to hold their personal funds in order to be admitted to the facility. Nursing homes must protect and account for any residents’ funds deposited with the facility.

**Readmission Following Hospital Stays**
Most residents have the right to be readmitted to their nursing home following a hospital stay. (For more information, see Chapter 5, pages 76–77.) Some nursing homes fail to inform residents of their readmission rights. Nursing homes are obligated to follow several key requirements:

- On admission, nursing homes must inform residents in writing of their right to “hold” a bed for up to seven days if they are transferred to a hospital. A “bedhold” means that a resident is guaranteed a bed in the nursing home upon the resident’s discharge from the hospital.
- Nursing homes must give residents notice of their “bedhold” rights at the time of transfer to the hospital.
- Admission agreements must explain that in the event the nursing home fails to follow required procedures for holding a bed, it must offer the resident the next available bed in the nursing home.
- Nursing homes must inform residents that Medi-Cal will pay for residents’ beds to be held up to seven days while residents are in the hospital.

**Nursing homes must inform residents in writing of their right to “hold” a bed for up to seven days if they are transferred to a hospital.**

**Residents’ Rights**
Nursing home residents retain the same rights and privileges as all citizens. However, some nursing homes fail to inform residents about their rights or fail to include a list of residents’
rights in the admission agreement.

Because residents’ rights are so important, the law requires that a comprehensive Patient’s Bill of Rights be attached to every admission agreement. The admission agreement also must contain a separate written acknowledgment that the resident has been informed of that Bill of Rights.

**TIP:** Residents should compare the list of rights in the Patient’s Bill of Rights to the provisions of the admission agreement and ask the nursing home to explain any differences.

**Transfers and Discharges**

Federal and state laws protect the rights of all residents to remain in their nursing homes by limiting the circumstances under which the residents may be involuntarily transferred or discharged. (For more information, see Chapter 5, pages 70–72.) However, some admission agreements incorrectly include more right-to-evict reasons than the law allows.

*Federal and state laws protect the rights of all residents to remain in their nursing homes by limiting the circumstances under which they may be involuntarily transferred or discharged.*

All admission agreements must state that, except in an emergency, residents cannot be involuntarily transferred or discharged from a nursing home unless they are given reasonable notice in writing and legally-required discharge planning. Admission agreements may not list any reason for transfer or discharge other than those specified by federal or state laws.

**Waivers of Liability**

Some admission agreements state that the nursing home is not legally responsible for injuries to its residents or their personal property. Other agreements require that residents release the nursing home from responsibility. These waivers of liability are illegal and unenforceable.
RESOURCES
For more information on topics in this chapter, consult the following agencies, print and online resources, and the legal citations on which the information is based.

Agencies
- Bet Tzedek Legal Services: www.bettzedek.org, (323) 939-0506
- California Advocates for Nursing Home Reform: www.canhr.org, (800) 474-1116
- California Department of Public Health, Licensing and Certification Division: www.cdph.ca.gov/programs/LnC, (800) 236-9747. (For phone numbers of local District Offices, see Appendix C, pages 118–120.)
- California Long-Term Care Ombudsman Program: www.aging.ca.gov/programs (search: “ombudsman”), CRISISline (800) 231-4024. (For phone numbers of local Ombudsman Programs, see Appendix B, pages 115–117.)

Print

Online
- California Advocates for Nursing Home Reform Fact Sheet, “Nursing Home Admission Agreements”: www.canhr.org/factsheets
Legal Citations
The discussions in this chapter are based primarily on Title 42 of the United States Code, sections 1395cc(f), 1395i-3(c) and 1396r(c); Title 42 Code of Federal Regulations sections 435.831(e), 483.10, 483.12, 483.15, 483.25, 489.22 and 489.102; California Code of Civil Procedure section 1295(c); California Health and Safety Code, sections 1289, 1418, 1419, 1420, 1430, 1432, 1439.8, 1599.1, 1599.61, 1599.62, 1599.63, 1599.65, 1599.66, 1599.67, 1599.69, 1599.70, 1599.71, 1599.72, 1599.74, 1599.76, 1599.78, 1599.79 and 1599.81; California Welfare & Institutions Code, sections 14006.3, 14006.4, 14019.3, 14022.3, 14022.4, 14108.2, 14110.8, 14110.9, 14124.10, and 14124.7; Title 22 of the California Code of Regulations, sections 51535, 72315, 72319, 72381, 72501, 72503, 72520, 72527, 72528(g), 72529, and 72531; California Department of Public Health, All Facilities Letter 11-55; Podolsky v. First Healthcare Corporation, 50 Cal. App. 4th 632, 58 Cal. Rptr. 2nd 89 (1996); Medicare Skilled Nursing Facility Manual, section 317.
CHAPTER 4
QUALITY OF CARE
The quality of care provided by a nursing home depends on a variety of factors. Measurable factors include the number and qualifications of the staff, sophistication of the medical equipment, and amount of money spent on patient care. Quality of care depends on less tangible factors too, such as staff attitude and the general atmosphere of the nursing home.

This chapter describes general care standards for nursing homes as well as the care planning process. In addition, it provides a list of specific care standards and related residents’ rights covered by state and federal law.

**General Care Standards**
State and federal laws try to ensure good care by requiring nursing homes to meet certain standards. Residents and family members can improve a nursing home’s quality of care by making sure that the nursing home complies with applicable laws and regulations. Too frequently, residents and family members do not question nursing homes on care issues because they think that they do not have enough knowledge to discuss the issues.

Advocating for your rights and the rights of your loved ones involves knowing the laws designed to help improve health, receive individualized care, and avoid discrimination.

**Improving and Maintaining Health**
Federal laws require that all nursing homes provide each resident “necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being.”

In general, that means that a resident’s condition should not get worse in a nursing home unless the individual’s condition makes such a decline inevitable. As its name implies, a nursing home is expected to nurse and rehabilitate its residents to improve or maintain their health.

**Federal laws require that all nursing homes provide each resident “necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being.”**

**Receiving Individualized Care**
Nursing home residents also have the right to “receive services in the facility with reasonable accommodation of individual needs and preferences.” Nursing homes must attempt to provide individualized care to support each resident’s choices about such issues as schedules, activities, and dining.

For example, if a resident prefers to sleep until 8:00 a.m., the nursing home should not wake him at 6:30 a.m. to eat breakfast. Instead, the nursing home can comply with the law by waking the resident at 8:00 a.m. and having cereal, fruit, and juice available for him and other residents who prefer to get up after the standard breakfast time.

**Avoiding Discrimination**
All nursing home residents are entitled to receive quality care, regardless of their source.
of payment. It is illegal for a nursing home to discriminate against a resident who receives financial assistance from Medi-Cal. A Medi-Cal recipient is entitled to the same level of care and services as any other nursing home resident.

**Care Planning Process**
Nursing home residents have the right to receive good care. To obtain good care, residents should take an active role in the care planning process. Care planning includes assessing a resident’s condition, preparing a multidisciplinary plan of action, and engaging key participants through periodic care conferences.

**Assessment**
A nursing home is required to conduct a comprehensive assessment of a new resident’s condition within two weeks of the individual’s admission to the nursing home. The nursing home uses the assessment to develop the care plan and measure changes in the resident’s condition. The assessment records a range of information about the resident’s condition, including the person’s:

- physical abilities
- care needs
- medications
- preferences regarding scheduling, activities, and relationships

The nursing home also must update the assessment whenever a significant change in condition occurs or at least every three months, whichever comes first. The assessment must be conducted or coordinated by a registered nurse.

**ASK THE EXPERTS—REASONABLE ACCOMMODATION**

*I run a nursing home, and this “reasonable accommodation” obligation seems like an impossible burden for me and my staff. How can I make accommodations for 100 residents?*

Regardless of the law, accommodating your residents’ needs and preferences is the right way to do business. Nothing is more destructive to a nursing home than an attitude that residents are all the same, or that they are medical cases rather than human beings. Recognition of resident needs—large or small—will make residents and family members happier, and will allow staff members to take real pride in the important work that they do.

Accommodation of individual resident needs is a cornerstone of many of the “culture change” reforms that are being adopted in nursing homes across the country. Examples include the California Culture Change Coalition (www.calculturechange.org), Eden Alternative (www.edenalt.com), The Green House Project (www.thegreenhouseproject.org), and the Pioneer Network (www.pioneernetwork.net).
**TIP:** Residents and family members should take an active role in the assessment to make sure that it reflects the conditions and preferences of the resident. Ask for a copy of the assessment and review it carefully.

**Care Plan**

Care plans are documents used by residents and nursing homes to guide the individual care of each resident. Each care plan incorporates a resident’s personal preferences, information from the assessment, and input from healthcare professionals. The care plan describes the care the resident requires and sets goals for maintaining or improving the resident’s condition.

The care plan must be prepared within seven days after the completion of a resident’s assessment. It is initially prepared by the resident’s physician or other medical provider, a registered nurse, and other appropriate nursing home staff, such as physical therapists, dietitians, and social workers. The care plan team also should include the resident and family members (if the resident wants family members to be involved).

To maximize its positive effects, the care plan should:

- Specifically describe the resident’s unique needs
- Specify how the nursing home will address the resident’s individual needs
- State goals for improving the resident’s condition
- Name the staff person(s) responsible for working to achieve the goals
- Provide an assessment of the resident’s progress and the nursing home’s performance within a specified period of time

Because the care plan is so important for ensuring quality care, the resident or family members should insist that the nursing home prepare a comprehensive care plan that incorporates all of the resident’s needs and preferences. Residents and family members should actively participate in the care planning process and insist that the care and goals described in the plan are met by the nursing home.

**TIP:** Residents and family members must remain vigilant and be prepared to respond quickly if they believe that the nursing home might be downplaying the importance of care plans, ignoring them completely, or drafting identical care plans for all residents. Such approaches often lead to poor care. Insist that the care plan reflect the unique needs and preferences of the resident and that the nursing home provide the care specified in the plan. Ask for a copy of the care plan and review it thoroughly.

**Care Plan Conferences**

Nursing home staff must review a resident’s
care plan every three months, or whenever there is a change in the resident’s condition. To ensure good care, the resident and/or family members should attend the care plan conferences. These conferences are opportunities to evaluate the resident’s progress and the nursing home’s performance and revise the care plan to reflect any changed circumstances or to set new goals for the resident and the nursing home. If there are problems, the resident or family members should insist that the nursing home improve its level of care or provide services that better match the resident’s preferences.

Specific Care Standards and Residents’ Rights
In addition to general care principles, nursing homes must comply with specific care standards and related residents’ rights set forth in state and federal laws. Those standards and related rights cover everything from activity programs to hospice care to visiting hours.

Activity Programs
A nursing home must provide activities for its residents, such as exercise, arts and crafts, religious services, games, and educational classes. Key principles include the following:

- Activity programs should meet the needs and interests of each resident, and help their self-care and resumption of normal activities.
- Each resident must have an individualized activity plan consistent with the resident’s treatment program.
- The activity program must follow a written, planned schedule.

Activities of Daily Living
Under federal law, a nursing home must help its residents maintain or improve their ability to speak, bathe, dress, groom, walk, eat, and use the toilet—tasks referred by healthcare professionals as activities of daily living, or ADLs. California law specifically requires that a nursing home provide necessary personal care services, including bathing, shampooing, teeth-brushing, shaving, and toenail and fingernail cuttings. If a resident is unable to perform these ADLs, the nursing home is required to assist the resident.

Bladder and Bowel Control
Residents must be assisted in maintaining or restoring normal bladder and bowel function. If a resident needs assistance to go to the bathroom or to use a bedpan, the nursing home must provide that assistance. Staff must help residents with toileting during the day and at night. The nursing home may never use adult briefs or urinary catheters for the

TO LEARN MORE
For more information about care standards and residents’ rights, see the California Advocates for Nursing Home Reform Fact Sheets, “Nursing Home Care Standards,” “Outline of Nursing Home Residents’ Rights,” and “Residents’ Rights” at www.canhr.org/factsheets.
convenience of staff instead of providing toileting assistance to residents.

**ASK THE EXPERTS—ASSISTING THE RESIDENT**

*My father wants to feed himself but the nursing assistants keep doing it for him. Can’t my father at least try to feed himself first?*

Yes, he can. In providing assistance, the nursing home must help its residents remain as independent as possible. It cannot try to save time or money by taking over tasks for its residents instead of assisting them in performing the tasks on their own.

If your father can feed himself if he is helped by a nursing assistant, the nursing assistant should not feed him. Instead, the nursing home should direct the nursing assistant to help your father feed himself or, if appropriate, provide him with special equipment to allow him to eat independently.

Dental, Hearing, and Vision Care

Nursing homes must arrange for their residents to receive necessary dental, hearing, and vision care. Services may be provided onsite or the nursing home can provide transportation to an outside office or clinic.

The nursing home is not required to pay for these services, however. Nursing home residents generally need to pay for dental, hearing, and vision care unless they have Medi-Cal or other health insurance coverage for those services.

**TIP:** Residents on Medi-Cal who need dental, hearing, or vision services not covered by Medi-Cal may be able deduct the costs (or other uncovered medical expenses) from the monthly share of cost set by Medi-Cal. To qualify for a reduction in share of cost, the resident must have a prescription for the services. The services must also be part of the physician’s plan of care, and they must be documented in the resident’s medical record at the nursing home. Residents with eligible expenses should give a copy of their prescriptions and bills to the nursing home. The nursing home should deduct the expenses from that month’s share of cost and bill the resident for the remaining amount.

If a resident has an indwelling urinary catheter, the nursing home must monitor the resident’s fluid intake and output. The nursing home must also take steps to prevent urinary tract infections.
Food
Federal and state regulations require nursing homes to provide nutrition to their residents, including the following:

- Nursing homes must provide residents with at least three meals each day.
- Nursing homes must offer bedtime snacks.
- Dinner during the evening and breakfast the following morning cannot be separated by more than fourteen hours.
- The nursing home must accommodate each resident’s food preferences as much as possible, including making substitutions from appropriate food groups.
- The nursing home must provide therapeutic diets if ordered by the resident’s physician.

Hospice services in a nursing home are generally paid for by Medicare and provided by an outside hospice agency that supplements the nursing home’s care. Hospice care is available under Medicare Part A if all of the following conditions are met:

- The resident is eligible for Medicare Part A coverage.
- The resident’s doctor and the hospice medical director certify that the resident is terminally ill and probably has six months or less to live.
- The resident signs a statement choosing hospice care instead of standard Medicare benefits for the terminal illness.
- The resident receives care from a Medicare-approved hospice program.

Medicare will pay for two 90-day periods of hospice care for a qualified nursing home resident, followed by an unlimited number of 60-day periods. At the beginning of each period, a physician must certify that the resident is terminally ill.

Medi-Cal will also pay for hospice care for qualified individuals.

Hospice Care
A nursing home resident who is terminally ill may elect to receive hospice care. Hospice care is specialized treatment that emphasizes supportive services rather than cure. Hospice care generally involves a team approach of physicians, nurses, social workers, clergy, counselors, and therapists, depending on individual and family needs. The nursing home remains responsible for the resident’s care even if the resident is receiving hospice services.

TO LEARN MORE
Medicare Hospice Benefits, an informative guide about hospice care published by Medicare, is available online at www.medicare.gov (search “medicare hospice benefits”) or by calling 1-800-MEDICARE (633-4227).
Physical Therapy, Occupational Therapy, and Speech Therapy
Under federal law, residents who can move their arms and legs well should not lose their range of motion while in a nursing home’s care unless a resident’s condition makes the loss unavoidable. Residents with limited range of motion must receive “appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.”

Federal law also requires that nursing homes provide rehabilitative services for the improvement or maintenance of a resident’s condition. These rehabilitative services include but are not limited to physical, occupational, and speech therapy. Rehabilitative services must be provided to any resident for whom the service is prescribed, including residents who receive financial assistance from Medi-Cal.

Physicians and Other Medical Providers
Nursing homes must ensure that each resident’s care is supervised by a physician. Residents have the right to choose their own physicians. The nursing home must have a substitute physician available to provide supervision and emergency medical care whenever the resident’s physician is unavailable. A physician generally must visit and evaluate the resident as often as necessary and at least once every 30 days.

The nursing home must keep the physician informed of the resident’s condition. For
example, the nursing home must notify the physician if a sudden or marked change in a resident’s condition occurs, the resident experiences an adverse response to a medication or treatment, or gains or loses five pounds during a 30-day period.

**Pressure Ulcers**
Pressure ulcers—also referred to as bed sores, decubitus ulcers, or pressure sores—are areas of damaged skin caused by staying in one position too long. Pressure ulcers form most often over areas where bones are close to the skin. Common pressure ulcer areas include the hips, heels, back, elbows, and ankles. These wounds can cause serious, potentially fatal infections.

*Pressure ulcers are areas of damaged skin caused by staying in one position too long.*

A resident should not develop pressure ulcers unless the resident’s condition makes them unavoidable. To prevent pressure ulcers, nursing home staff must turn or shift the position of residents who cannot move on their own. If ulcers develop, the nursing home must provide treatment to heal the ulcers and prevent infection.

The nursing home also must notify the resident’s physician when a pressure ulcer develops or treatment of an ulcer is not effective. The notification must be documented in the resident’s medical record.

**Restraints**
Residents have the right to refuse physical and chemical restraints. A *physical restraint* is a device that restricts a resident’s freedom of movement or ability to gain access to the body. Examples of physical restraints include bed rails, geri-chairs, hand mitts, Posey vests, and soft ties. A *chemical restraint* is a drug prescribed to control a resident’s mood, mental status, or behavior.

Under federal law, nursing home residents have “the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required
Restraints may be imposed only “to ensure the physical safety of the resident or other residents” and must be ordered by a physician in writing. That note must specify the length of time and the circumstances under which the restraints are to be used.

Under California law, restraints must be ordered by a physician and cannot be applied for disciplinary purposes or the convenience of a nursing home’s staff. All physical restraints must cause the least discomfort to the resident and must also allow for speedy removal in case of an emergency. Physical restraints to control behavior may be used only as part of a plan to lead to less restrictive care.

Excessive use of drugs is the most common form of abuse in nursing homes. One out of four California nursing home residents are given drugs to control and sedate them. Residents can always refuse drugs or other restraints, even if they are ordered by a physician. Restraints cannot be imposed on a resident unless the resident or resident’s representative consents to the restraint. The resident or representative can withdraw consent at any time.

Restraints cannot be imposed on a resident unless the resident or resident’s representative consents to the restraint.

Schedules
When organizing schedules for its residents, nursing homes are required to make “reasonable accommodations” to meet each resident’s individual needs and preferences. For example, if a resident prefers a bath to a shower and likes to be clean for weekend visitors, the nursing home should accommodate the resident’s preferences.

Staffing
Nursing homes must employ and schedule enough licensed nurses, certified nursing assistants, and other staff to meet the care needs of all its residents. In addition, California requires nursing homes to provide a minimum of 3.2 hours of nursing care per resident per day. A nursing home is not excused from providing required services because it does not have enough staff.

TIP: A nursing home must post in a clearly visible place, for each shift, the current number of licensed and unlicensed nursing staff directly responsible for resident care.

TO LEARN MORE
Comprehensive information about the misuse of drugs in nursing homes is available online at the website of the California Advocates for Nursing Home Reform at www.canhr.org/stop-drugging, and in its consumer guide, Toxic Medicine—What You Should Know to Fight the Misuse of Psychoactive Drugs in California Nursing Homes. Toxic Medicine is available for download at www.canhr.org (search: “toxic medicine”).

Excessive use of drugs is the most common form of abuse in nursing homes. One out of four California nursing home residents are given drugs to control and sedate them. Residents can always refuse drugs or other restraints, even if they are ordered by a physician. Restraints cannot be imposed on a resident unless the resident or resident’s representative consents to the restraint. The resident or representative can withdraw consent at any time.

Restraints cannot be imposed on a resident unless the resident or resident’s representative consents to the restraint.

Schedules
When organizing schedules for its residents, nursing homes are required to make “reasonable accommodations” to meet each resident’s individual needs and preferences. For example, if a resident prefers a bath to a shower and likes to be clean for weekend visitors, the nursing home should accommodate the resident’s preferences.

Staffing
Nursing homes must employ and schedule enough licensed nurses, certified nursing assistants, and other staff to meet the care needs of all its residents. In addition, California requires nursing homes to provide a minimum of 3.2 hours of nursing care per resident per day. A nursing home is not excused from providing required services because it does not have enough staff.

TIP: A nursing home must post in a clearly visible place, for each shift, the current number of licensed and unlicensed nursing staff directly responsible for resident care.
Visitors
Nursing homes are required to allow family members to visit the resident anytime the resident wants. Families do not have to visit during nursing home visiting hours. If requested, the nursing home must allow family visits to take place privately.

Similarly, a resident’s friends must be allowed to visit the resident at any time if the resident wishes to see them. However, the nursing home can place “reasonable restrictions” on social visits from non-family members, such as requiring that the visits take place outside the room if the resident’s roommate is sleeping.

Nursing homes are required to allow family members and friends to visit the resident anytime the resident wants.

Each resident’s physician or Ombudsman (resident-advocate who investigates and helps to resolve complaints) must be allowed to meet with the resident at any time. If the resident desires, an individual who provides health, social, or legal services to the resident must also be given “reasonable access.”

ASK THE EXPERTS—VISITOR RESTRICTIONS
My mom is in a nursing home, and my brother has instructed the nursing home to stop me from visiting. Is this legal?

Probably not. A nursing home resident controls her own visitation rights. Other people may not restrict a resident’s visitors unless the resident cannot communicate or has been determined by a court to have lost the capacity to make decisions. Your mother’s choices about visitors may not be overridden by a family member, agent under Power of Attorney, physician, or nursing home. The only person who may override a resident’s visitation preferences is a court-appointed conservator with special powers regarding visitation.

ASK THE EXPERTS—VISITING HOURS
My son works until 7:00 p.m. and wants to visit me at 8:00 p.m. The nursing home says that visiting hours end at 7:30 p.m. Can my son visit me after 7:30 p.m.?

Yes, he can. Your right to visit with family members and friends cannot be limited by the nursing home’s visiting hours.
RESOURCES
For more information on topics in this chapter, consult the following agencies, print and online resources, and the legal citations on which the information is based.

Agencies
• Bet Tzedek Legal Services: www.bettzedek.org, (323) 939-0506
• California Advocates for Nursing Home Reform: www.canhr.org, (800) 474-1116
• California Department of Public Health, Licensing and Certification Division: www.cdph.ca.gov/programs/LnC, (800) 236-9747. (For phone numbers of local District Offices, see Appendix C, pages 118–120.)
• California Long-Term Care Ombudsman Program: www.aging.ca.gov/programs (search: “ombudsman”), CRISISline (800) 231-4024. (For phone numbers of local Ombudsman Programs, see Appendix B, pages 115–117.)

Print
• Eric M. Carlson and Katherine Bau Hsiao, The Baby Boomer’s Guide to Nursing Home Care, Chapter 6, ©2006, Taylor Trade Publishing

Online
• California Advocates for Nursing Home Reform Fact Sheet, “Making Care Plans Work”: www.canhr.org/factsheets
• California Advocates for Nursing Home Reform Fact Sheet, “Nursing Home Care Standards”: www.canhr.org/factsheets
• California Advocates for Nursing Home Reform Fact Sheet, “Outline of Nursing Home Residents’ Rights”: www.canhr.org/factsheets
• California Advocates for Nursing Home Reform Fact Sheet, “Residents’ Rights”: www.canhr.org/factsheets
• California Advocates for Nursing Home Reform, “The Campaign to Stop Chemical Restraints in Nursing Homes”: www.canhr.org/stop-drugging


**Legal Citations**

The discussions in this chapter are based primarily on *Title 42 of the United States Code, sections 1395d(d), 1395f(a)(7), 1395i-3, 1395x(dd), and 1396r; Title 42 of the Code of Federal Regulations, sections 418.20-418.24, 483.10, 483.13, 483.15, 483.20, 483.25 and 483.45; Interpretative Guidelines to Title 42 of the Code of Federal Regulations, section 483.13; California Civil Code, section 1668; California Health & Safety Code, sections 123110, 1418.2 through 1418.4 and 1418.9; California Probate Code, section 4689; California Welfare and Institutions Code, section 14124.10; Title 22 of the California Code of Regulations, sections 72527, 72528, 72303, 72307, 72311, 72315, 72319, 72335 and 72379 through 72389; California Judicial Council Form GC 341; *Tunkl v. Board of Regents*, 60 Cal. 2d 92, 32 Cal. Rptr. 33 (1963).
CHAPTER 5
TRANSFERS
AND DISCHARGES
A nursing home is literally “home” to many of its residents, and the law is very protective of the right of residents to remain in their homes. This chapter discusses the limited circumstances under which a nursing home can legally transfer or discharge a resident against his wishes. It includes information about lawful and unlawful reasons for involuntary transfers and discharges, procedures for appealing a transfer or discharge, the right to return to a nursing home following a hospitalization, and transfers within a nursing home.

Lawful and Unlawful Reasons
Nursing home residents, like tenants in an apartment building, generally have the right to stay where they are living, even if the nursing home would prefer for them to move out. Legally, residents can be evicted only for limited reasons, though some nursing homes attempt to transfer or discharge for improper or illegal reasons.

Lawful Reasons
A nursing home resident can be involuntarily transferred or discharged only under one or more of the following six circumstances:

1. The resident’s needs have changed, and the nursing home can no longer meet the resident’s needs.
2. The resident’s health has improved, and he no longer needs the services of a nursing home.
3. The resident’s presence in the nursing home endangers the health of others.
4. The resident’s presence in the nursing home endangers the safety of others.
5. The resident has failed to pay for his stay at the nursing home after having received reasonable and appropriate notice of nonpayment.
6. The nursing home ceases to operate and closes.

Other than for these six reasons, nursing homes generally are not allowed to transfer or discharge residents against their will.

TIP: Transfer and discharge laws apply to all nursing homes. The average length of stay of a nursing home resident is irrelevant. For example, a hospital’s transitional care unit, which is licensed as a nursing home, must follow all transfer and discharge laws and may not evict residents for improper reasons.

Unlawful Reasons
Some nursing homes attempt to justify transfers or discharges with unlawful reasons. An unlawful reason is any reason other than the six legal reasons discussed above. If the nursing home’s decision to transfer or discharge a resident is based on an improper reason, the resident should appeal the decision.

Some nursing homes attempt to justify transfers or discharges with improper reasons.
Payment Issues

Payment problems are one of the most common unlawful reasons for evictions from nursing homes. Denial of payment by Medi-Cal, Medicare, or an insurance company is not among the six legal reasons for transfers or discharges and so is an improper basis for an eviction. In addition, a denial by the Medicare program or an insurance company is not the same as nonpayment. The denial does not prevent the nursing home from receiving payments from the resident, Medi-Cal, or

EXAMPLES OF UNLAWFUL REASONS FOR TRANSFER OR DISCHARGE

Here are common examples of reasons nursing homes might give for transferring or discharging a resident. All of these reasons are improper.

- Resident is disruptive or difficult to manage.
- Resident does not follow facility policies.
- Resident refuses medical treatment.
- Resident or family expectations are unreasonable.
- Resident needs a different type of nursing home.
- Caring for resident has become too burdensome or expensive.
- Resident’s behavior exposes facility to potential legal liability.
- Resident does not need facility’s specialized services.
- Medicare coverage is ending.
- Medi-Cal has ruled that the resident does not need nursing home care.
- Resident’s timely application for Medi-Cal is pending, but the facility has not yet been paid.

ASK THE EXPERTS—EVICTION FOR NON-PAYMENT: PAPERWORK SUBMITTED

I submitted the necessary paperwork to my insurance company to pay my nursing home bill, but it hasn’t been paid yet. Now the nursing home is threatening to evict me. Can I be evicted for non-payment?

No, you cannot. Residents cannot be evicted for non-payment if they have submitted all of the necessary paperwork to such third-party payers as an insurance company, Medicare, or Medi-Cal. However, if your insurance company denies your claim and in turn you refuse to pay, the facility can take steps to evict you for non-payment.
another source. However, if the nursing home is not receiving payment for the resident’s care from any source, it may evict the resident for non-payment.

Nursing homes are also prohibited from involuntarily transferring or discharging residents who have made a timely application for Medi-Cal and for whom an eligibility determination has not yet been made.

**Denial of payment by Medi-Cal, Medicare, or an insurance company is an improper basis for an eviction.**

**Notice Requirements**

Nursing homes must give residents and their family members or legal representatives adequate notice of their plans to transfer or discharge a resident. The notice generally must be given at least 30 days before the proposed transfer or discharge date.

Notice of a transfer or discharge must be written and must specify several key points:

- Reason for the transfer or discharge
- Effective date of the transfer or discharge
- Location to which the resident will be transferred

The notice must also inform residents and family members or legal representatives that they can appeal the nursing home’s decision to the California Department of Health Care Services (DHCS). The notice must list the telephone number and address for the DHCS as well as the local offices of the Ombudsman Program.

**Discharge Planning Requirements**

Nursing homes are required to adequately prepare residents for transfer or discharge, whether voluntary or involuntary. The nursing home must provide sufficient preparation and orientation to the resident to ensure a safe and
Transfers and Discharges

orderly transfer or discharge from the facility. Federal guidelines state that this preparation could include the resident being allowed trial visits to his new nursing home and ensuring that the resident does not lose any personal possessions.

The nursing home must also provide sufficient discharge and post-discharge planning. This planning includes the development of a post-discharge plan of care to help the resident adjust to his new living environment. It also includes a demonstration of how the resident’s needs will be met in the new facility.

Appeals

Residents have the right to appeal a nursing home’s attempted transfer or discharge. A resident who wishes to remain in the nursing home should appeal an eviction if he believes it is improper. To begin the appeal, the resident should follow these steps:

- Call the Transfer/Discharge and Refusal to Readmit Unit of the DHCS at (916) 445-9775 or (916) 322-5603.
- Ask DHCS for a Transfer/Discharge appeal hearing.

Residents should contact the DHCS as soon as possible to appeal their transfer or discharge, and no later than 10 days after receipt of the written transfer/discharge notice.

Residents have the right to appeal a nursing home’s attempted transfer or discharge.

Appeals Process

After the DHCS receives an appeal of a transfer or discharge notice, it will schedule a hearing at the nursing home. At the hearing, a hearing officer will listen to the statements of the resident, resident’s family members, nursing home staff, and any other witnesses. The hearing officer also may review medical records and documents presented by the witnesses. About one week after the hearing, the hearing officer will issue a written decision explaining why the nursing home can or cannot transfer or discharge the resident.
If the resident wins, he has the right to remain in the nursing home. If the resident loses but believes that the decision was wrong, he should immediately consult an attorney to consider an appeal of the decision to the California Superior Court.

Preparing for a Transfer/Discharge Hearing
To prepare for the hearing, the resident should consider the legal requirements for transfers and discharges discussed in this chapter. The resident should determine which legal arguments apply to the resident’s case and what evidence such as witnesses and documents supports the arguments.

Legal Arguments
In general, residents should focus on three key areas:

- Reasons for the transfer or discharge
- Notice of the transfer or discharge
- Discharge planning

Residents should emphasize that the nursing home’s alleged reasons are not among the six legitimate reasons for an involuntary transfer or discharge.

The resident should review the six lawful reasons for an involuntary transfer or discharge on page 70 and be prepared to show that none of those six reasons apply to the resident’s situation. The resident should emphasize that the nursing home’s alleged reasons are not among the six legitimate reasons. If appropriate, the resident should point out how the nursing home’s actions might have caused the problems leading up to the eviction.

In addition, the resident should point out any defects in the nursing home’s notice of transfer or discharge. Federal and state laws set forth specific requirements for transfer and discharge.

DHCS has set a hearing next week on my appeal of the nursing home’s decision to discharge my husband. We have no idea what to expect. How can we prepare for something like this?

Hearings on involuntary transfers and discharges are less formal than court proceedings, but advance preparation can improve the likelihood of success. Residents can and often do represent themselves at the hearing, so you do not need to hire an attorney. However, a knowledgeable attorney can be very helpful. You may also find it helpful to invite a Long-Term Care Ombudsman to the hearing, especially if the Ombudsman is knowledgeable about your husband’s situation. Explain to the hearing officer why the discharge is inappropriate, and base your arguments on the legal requirements for evictions discussed in this chapter.
Transfers and Discharges

discharge notices, and an involuntary transfer or discharge will not be approved unless the notice complies with the law.

Finally, if appropriate, the resident should argue that the nursing home failed to provide sufficient discharge planning.

**EXAMPLES OF TRANSFER/DISCHARGE CASES AND DECISIONS**

These next four cases are examples of actual transfer/discharge appeals and their results.

**Case 1: Alcohol Abuse**
A nursing home alleged that a resident had violated facility policy by abusing alcohol. Because the reason given for the discharge was not one of the six legal reasons for transfer or discharge, the hearing officer ruled in the resident’s favor.

**Case 2: Medi-Cal TAR Denial**
A nursing home gave a letter to its resident stating that the facility was discharging him because Medi-Cal denied a *Treatment Authorization Request* (TAR) for his nursing home care. The hearing officer found that the facility’s letter failed to list one of the six allowable reasons for an involuntary transfer/discharge and ruled in the resident’s favor. The hearing officer also stated that the proposed discharge location to the resident’s “Place of Choice” or assisted living facility was legally insufficient because it was undisputed that the resident needed nursing home care and neither of the proposed locations provided that level of care.

**Case 3: Mental Illness**
A nursing home alleged that it could not meet a resident’s needs because she refused to take drug therapy for her mental illness and because she could not maintain the services of an attending physician. At the hearing, the resident testified that she did not need drug therapy. She submitted documents showing her attempts to obtain a physician. The hearing officer decided in the resident’s favor. The hearing officer stated that the facility did not have the necessary documentation from the resident’s doctor to support the nursing home’s reasons for the discharge. The hearing officer also stated that the proposed discharge location to the resident’s “Place of Choice” or assisted living facility was legally insufficient because it was undisputed that the resident needed nursing home care and neither of the proposed locations provided that level of care.

**Case 4: Specialized Care**
A nursing home wanted to create a specialization in ventilator care. Ventilators are machines that support breathing, either partially or fully. The nursing home tried to force a resident out because he did not need a ventilator. The hearing officer noted that the facility could not prefer a ventilator-dependent applicant over a resident living at the facility and ruled in the resident’s favor.
Witnesses and Documents
If possible, the resident should bring to the hearing any people or documents that support his case. For example, the resident should ask family members, friends, and the resident’s physician to attend the hearing as witnesses, or to prepare written statements for the hearing officer if they cannot attend the hearing. The resident should also get copies of relevant records from the nursing home, such as medical charts, care plans, and discharge planning notes. If the resident has time, he may want to prepare a written statement to give to the hearing officer summarizing why the eviction is wrong. However, no written statement is required.

Readmissions from Hospitals
Many nursing home residents have health problems that require them to go to hospitals for treatment. Residents do not automatically lose their place in nursing homes during hospital stays. Hospitalized residents usually have the right to return to their nursing homes.

Bed-Holds
The law requires that nursing homes allow residents or family members to hold a nursing home bed, called a bed-hold, for up to seven days of a hospital stay. If the resident is on Medi-Cal, the Medi-Cal program will pay for the bed-hold. Medicare does not pay for bed-holds, but residents whose care is being paid for by Medicare may pay for bed-holds with their own funds.

Nursing homes must inform their residents in writing of the right to a seven-day bed-hold when residents are admitted to the nursing home and again on transfer of the resident to a hospital. If the nursing home fails to comply with this requirement, it must offer the resident its next available bed at the conclusion of the resident’s hospital stay.

The law requires that nursing homes allow residents or family members to hold a nursing home bed for up to seven days of a hospital stay.

Residents who are on Medi-Cal have a right to be readmitted to the next available bed in their nursing home even if their stay in a hospital is longer than seven days.

Refusals to Readmit
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 so are excused from following readmission laws.

This argument is almost always untrue. In nearly all instances, the nursing home actually can meet the resident’s needs but may view such a scenario as an opportunity to discharge a resident it considers to be difficult or unprofitable.

Readmission Appeals
Residents who are refused readmission to their nursing homes should immediately request a readmission hearing from the Transfer/Discharge and Refusal to Readmit Unit of the
A resident who appeals a nursing home’s refusal to readmit him should be able to remain in the hospital until a hearing decision is issued.

If the resident is on Medi-Cal, the Medi-Cal program will pay the hospital for the resident’s care until the hearing decision is issued. If the resident’s hospital stay is not covered by Medi-Cal or another source of payment, the hearing decision must be issued extremely quickly—within 48 hours after the request for hearing is made.

**Transfers Within Nursing Homes**

Nursing homes should try to accommodate residents’ choices regarding rooms and roommates. Nursing homes must give residents written notice before moving them into a different room or changing a roommate. Residents are entitled to refuse such transfers if they are based on a change in the resident’s payment source such as switching from Medicare to Medi-Cal.

**ASK THE EXPERTS—NURSING HOME READMISSION**

*I am on Medi-Cal and have been in a hospital for three weeks. The hospital is ready to discharge me, and I want to go back to my nursing home, but it is refusing to readmit me. What should I do?*

You should immediately request a readmission hearing from the DHCS. Because you are eligible for Medi-Cal, the nursing home must readmit you to the first available bed, no matter how long you have been in the hospital. In addition, Medi-Cal will pay for your hospital stay until the hearing decision is issued.

**ASK THE EXPERTS—MEDICARE BEDS**

*My mother has been in a nursing home for about ten days, receiving physical therapy during the weekdays. The bills have been paid by Medicare Part A. I was told today that the therapy and the Medicare payments were ending immediately, because my mother was no longer showing improvement. I was also told that my mother would be transferred down the hall because she no longer could be in a “Medicare bed.” Is there anything that I can do?*

Yes, there is. Lack of improvement is not necessarily a reason for discontinuing therapy or for stopping payment under Medicare Part A. Try to persuade your mother’s physicians and therapists to continue therapy. Tell the nursing home to continue billing Medicare Part A for your mother’s care. If necessary, file an appeal with Medicare. Finally, you and your mother should inform the nursing home that she is refusing the down-the-hall transfer. Residents cannot be moved merely to free up a so-called “Medicare bed.” For more information on Medicare appeals, see Chapter 2, pages 24–28.
Nursing homes often try to transfer residents to another room when their Medicare coverage ends. Nursing homes incorrectly claim that Medicare rooms must be occupied by residents currently receiving Medicare reimbursement for their nursing home stay. In fact, Medicare rooms can be occupied by any resident, regardless of their source of payment.

It is illegal for nursing homes to discriminate against residents whose care is paid for by Medi-Cal. Nursing homes may not transfer residents to different rooms because they have applied for Medi-Cal or are eligible for Medi-Cal. However, the nursing home may transfer a resident who is a Medi-Cal recipient from a private room to a semi-private room.
RESOURCES
For more information on topics in this chapter, consult the following agencies, print and online resources, and the legal citations on which the information is based.

Agencies
• Bet Tzedek Legal Services: www.bettzedek.org, (323) 939-0506
• California Advocates for Nursing Home Reform: www.canhr.org, (800) 474-1116
• California Department of Health Care Services, Transfer/Discharge and Refusal to Readmit Unit: (916) 445-9775 or (916) 322-5603
• California Department of Public Health, Licensing and Certification Division: www.cdph.ca.gov/programs/LnC, (800) 236-9747. (For phone numbers of local District Offices, see Appendix C, pages 118–120.)
• California Long-Term Care Ombudsman Program: www.aging.ca.gov/programs (search: “ombudsman”), CRISISline (800) 231-4024. (For phone numbers of local Ombudsman Programs, see Appendix B, pages 115–117.)

Print
• Eric M. Carlson and Katherine Bau Hsiao, The Baby Boomer’s Guide to Nursing Home Care, Chapter 8, ©2006, Taylor Trade Publishing
• Eric M. Carlson, Long-Term Care Advocacy, Chapter 4, ©2010, LexisNexis

Online
• California Advocates for Nursing Home Reform Fact Sheet, “Transfer and Discharge Rights”: www.canhr.org/factsheets

Legal Citations
The discussions in this chapter are based primarily on Title 42 of the United States Code, sections 1395i-3(c), 1396r(c), 1396r(e), and 1396r(f); Title 42 of the Code of Federal Regulations, sections 483.10, 483.12, and 483.20(l); California Health & Safety Code, section 1599.1 (b); California Welfare & Institutions Code, section 14124.7; Title 22 of the California Code of Regulations, sections 51535, 72520 and 72527(a)-(b); California Department of Health Services Licensing and Certification Policy and Procedure Manual, section 618; In re E.O., California Transfer/Discharge Appeal No. 93-1331 (July 17, 2006); In re E.B., California Transfer/Discharge Appeal No. 97-1304 (April 4, 2006); In re E.D., California Transfer/Discharge Appeal No. 92-1289 (January 20, 2006); In re E.R., California Transfer/Discharge Appeal No. 97-0211 (May 1, 1995).
CHAPTER 6
PROTECTING RESIDENTS’ PROPERTY
Nursing home residents might not have the physical or mental strength to safeguard their own property. The large number of people who work and live in nursing homes also increases the risk of lost or stolen property. This chapter discusses what nursing homes must do to protect residents’ funds and personal property, liability for lost or stolen property, and protections against financial abuse.

Residents’ Funds
Nursing home residents have the right to manage their own financial affairs. A nursing home may not require a resident to deposit personal funds with the facility. However, residents can require that their nursing home hold their personal funds or property. Nursing homes must hold, safeguard, and account for a resident’s personal funds if the resident requests them to do so.

Nursing home residents have the right to manage their own financial affairs.

Nursing homes must deposit all resident funds over $50 into an interest-bearing account separate from the nursing home’s operating account. Any interest accrued in that account must be properly applied to each resident’s account. Nursing homes cannot apply a resident’s funds to pay for nursing home services unless the resident gives them permission.

TIP: Nursing homes must purchase a surety bond or other acceptable guarantee to protect the security of all personal funds of residents deposited with the facility.

Residents’ Personal Property
Nursing homes are required to protect residents’ personal property, and may have to reimburse residents for lost or stolen property if they fail to do so.

Nursing Home Responsibilities
All nursing homes are required to maintain a program aimed at reducing the loss and
theft of residents’ property. As part of this program, nursing homes must inventory a resident’s personal property when the resident enters the nursing home.

The facility also must mark the resident’s property for identification purposes, such as engraving the resident’s name on dentures or tagging prosthetic devices.

*All nursing homes are required to maintain a program aimed at reducing the loss and theft of residents’ property.*

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

**TIP:** Residents should make sure that all of their property is inventoried accurately and that the inventory is kept up-to-date. Ask for a copy of the original inventory and an updated inventory each time it is modified.

Nursing homes are required to keep records of all lost and stolen personal property valued at $25 or above. The records must include the property’s description, its approximate value, the date and time the theft or loss was discovered or occurred, and the actions taken by the nursing home. If stolen property is worth at least $100, the nursing home must report the theft to local law enforcement within 36 hours.

**ASK THE EXPERTS—PROTECTING PERSONAL PROPERTY**

*My father just moved into a nursing home, and I am concerned that his belongings will get lost or stolen. What can my father do to help protect his personal property?*

Residents can take several steps to help protect their personal property. First, they should make sure that the nursing home properly inventories their personal property, and keeps the inventory up-to-date. In general, nursing homes can be held financially responsible only for those items on the inventory, so residents should make sure that the inventory is accurate.

Residents should also make sure that the nursing home marks their property. In particular, make sure that glasses, hearing aids, prosthetic and orthopedic devices, dentures, walkers, and clothing are marked. Residents should ask the nursing home for a locked storage space such as a drawer or cabinet. If requested, nursing homes must provide a lock for the resident’s drawer or cabinet, though the resident can be required to pay for the cost of the lock.

If at all possible, residents should not keep valuable or irreplaceable items at the nursing home.
Nursing Home Liability for Lost or Stolen Property
Nursing homes that fail to protect their residents’ personal property may be financially responsible if the property is lost or stolen. Nursing homes are required to reimburse residents for lost or stolen personal property or replace the items if the facility failed to make reasonable efforts to safeguard the property.

TIP: Many nursing homes maintain insurance for their residents’ property. Do not hesitate to request reimbursement for lost or stolen property.

TIP: A resident’s claim for reimbursement is more likely to be successful if the items were marked with the resident’s name and listed on the resident’s inventory.

ASK THE EXPERTS — LOSS OR THEFT OF PROPERTY
I’ve been in a nursing home for about six months now, and I think someone stole a watch and ring from my bedside stand. What should I do?

If you think your property has been lost or stolen, you should notify the nursing home staff immediately, and request their assistance in finding the items. If the items cannot be located, ask that the nursing home reimburse you for the value of the items. It is helpful to put your request in writing and provide photographs and receipts, if available, to establish the value of the items. If the nursing home refuses to reimburse you for missing property, you can sue the facility in small claims court for the property’s replacement value.

You can also contact the Long-Term Care Ombudsman or the Department of Public Health for assistance in investigating the missing items and seeking reimbursement.

Protections Against Financial Abuse
Nursing home residents are uniquely vulnerable to financial abuse because of factors such as age, medications, mental health, and physical illnesses. Laws regulating financial transactions between nursing home staff and residents are designed to protect residents and prevent such abuse.
Control of Residents’ Funds
Nursing homes are prohibited from acting as a resident’s court-appointed conservator, or as a representative payee for the resident’s Social Security and/or Supplemental Security Income (SSI) checks. A conservator is an individual appointed by a court to act on behalf of an incapacitated adult. Conservators can be granted the power to determine the resident’s medical treatment, place of residence, or finances.

A representative payee helps residents receiving Social Security and/or SSI to manage their benefits. Representative payees use the resident’s benefits to pay for current and foreseeable costs, put into savings any remaining benefits, and maintain records of how benefits are spent.

Nursing homes are prohibited from acting as a resident’s conservator or representative payee of the resident’s Social Security and/or SSI checks.

State regulations prohibit nursing homes from acting as conservators or representative payees because of the potential conflict of interest. In addition, no employee or agent of a nursing home can act as a resident’s conservator or representative payee unless the employee or agent is the resident’s close relative. (For more information on conservators, see Chapter 7, pages 94–96.)

Gifts from Residents to Nursing Homes
To prevent nursing homes from taking financial advantage of residents, the law places restrictions on certain individuals who purchase or receive any item or property from a resident with a value of more than $100. Those individuals include the following:

- Nursing home owners, employees, agents, or consultants, or their immediate family members
- Representatives of a public agency or organization operating within the nursing home, or their immediate family members

The law places restrictions on certain individuals who purchase or receive any item or property from a resident with a value of more than $100.

If a resident wishes to sell or give such individuals property valued at more than $100, the transaction must be conducted in the presence of a representative of the Long-Term Care Ombudsman Program. In addition, the details of the transaction must be recorded by the nursing home in the health records of the resident, including the following information:

- Name and address of purchaser
- Date and location of transaction
- Description of property sold
- Purchase price

The record must then be signed by the resident, purchaser, and witnessing ombudsman.
RESOURCES
For more information on topics in this chapter, consult the following agencies, print and online resources, and the legal citations on which the information is based.

Agencies
- Bet Tzedek Legal Services: www.bettzedek.org, (323) 939-0506
- California Advocates for Nursing Home Reform: www.canhr.org, (800) 474-1116
- California Department of Public Health, Licensing and Certification Division: www.cdph.ca.gov/programs/LnC, (800) 236-9747. (For phone numbers of local District Offices, see Appendix C, pages 118–120.)
- California Long-Term Care Ombudsman Program: www.aging.ca.gov/programs (search: “ombudsman”), CRISISline (800) 231-4024. (For phone numbers of local Ombudsman Programs, see Appendix B, pages 115–117.)

Print

Online

Legal Citations
The discussions in this chapter are based primarily on Title 42 of the United States Code, sections 1395i-3(c)(6) and 1396r(c)(6); Title 42 of the Code of Federal Regulations, section 483.10(c); California Health & Safety Code, sections 1289, 1289.3 through 1289.5 and 1418.7; and Title 22 of the California Code of Regulations, sections 72501, 72527, and 72529.
CHAPTER 7
MAKING
HEALTHCARE
DECISIONS
All adults, including nursing home residents, have the right to make decisions about their own health care. Problems may arise, however, if a resident becomes suddenly incapacitated, or unable to communicate due to a stroke, disease, accident, or other event. Because no one knows when or if they will become incapacitated, planning ahead is the best way to make sure that a resident’s preferences regarding future medical care are known and followed.

This chapter examines healthcare decision-making, including planning documents, appointing other decision-makers, and a resident’s right to die.

**Directing Future Health Care**
All adults should appoint another person to make health care decisions for them should they become incapacitated. Nursing home residents who are incapacitated and have no legal representative might not receive needed medical treatment consistent with their desires. They also might not be able to refuse medical treatment that could prolong their lives even if they have no realistic prospect of recovery.

On the other hand, residents who have appointed another person to make future healthcare decisions for them can make sure that their wishes are carried out. The healthcare appointee can make those decisions in a way most consistent with the resident’s expressed desires.

Adults of all ages and health conditions can benefit by appointing a family member or friend to make future healthcare decisions should the appointing person become incapacitated.

**TIP:** Everyone, whether or not in a health care facility, should select a health care agent and complete an Advance Health Care Directive.

**Key Documents**
In California, there are several legal documents people can use to express their wishes about future medical care. These documents are discussed below.

**Power of Attorney for Health Care.** The Power of Attorney for Health Care allows an individual to appoint another person to act as his agent. The agent makes healthcare decisions if the individual becomes incapacitated.
**Individual Health Care Instruction.** This document allows individuals to list specific instructions for future health care, including whether they want to donate organs or, if needed, have a feeding tube or breathing machine.

**Do Not Resuscitate form.** This document allows an individual to specify that he does not wish to receive emergency resuscitative measures such as cardiopulmonary resuscitation (CPR).

**Physician Orders for Life-Sustaining Treatment form.** The Physician Orders for Life-Sustaining Treatment form, or POLST, converts a seriously ill individual’s wishes regarding end-of-life treatment into a physician’s order.

**TIP:** The Power of Attorney for Health Care and the Individual Health Care Instruction documents are often combined into a single form called an Advance Health Care Directive (AHCD). This guide will use AHCD to refer to the Power of Attorney for Health Care and the Individual Health Care Instruction documents.

**Advance Health Care Directives**

In California, nursing home residents can appoint another person (the “agent”) to make healthcare decisions for the resident by completing an Advance Health Care Directive (AHCD). The AHCD is a legally binding document that allows the agent to make healthcare decisions for the resident if the resident becomes unable to make or communicate such decisions.

The AHCD allows a physician, hospital, or nursing home to receive clear instructions about the resident’s wishes, even though the resident can no longer provide those instructions.

**ASK THE EXPERTS—CHOOSING AN AGENT**

*I need to choose someone to act as my agent for an Advance Health Care Directive. How do I go about making that decision?*

Try to select as an agent someone who knows you well, can follow your wishes, and feels free to discuss life and death issues with you. The agent can be a family member, friend, or other person. Your agent may not be one of your healthcare providers, nor an owner or employee of the nursing home in which you live.

No matter whom you choose, always select one or two alternate agents in case your primary agent is unable or unwilling to act as you have requested.

Always select one or two alternate agents in case your primary agent is unable or unwilling to act as you have requested.
Giving Specific Healthcare Instructions to the Agent

A nursing home resident can provide specific instructions to an agent appointed through an AHCD, in writing and orally. Most AHCD forms include an optional section for residents to declare their desire to receive or not receive life-sustaining treatment and under what conditions. Those sections also often provide space for residents to list specific instructions relating to health care decisions that they wish to express, such as whether they want to donate organs or to be given a feeding tube or breathing machine.

**TIP:** Residents should discuss personal desires and beliefs with their healthcare agent.

In addition to written instructions, residents should discuss their wishes with their agents. Discussing health care decisions now, while the resident is able to explain his preferences, can give the agent a greater sense of comfort about making difficult decisions that may one day prove necessary.

Written Healthcare Instructions

An AHCD enables a resident to state his preferences regarding future health care even if the resident has no agent specified. The instructions must be honored by healthcare providers if the individual can no longer make or communicate his own healthcare decisions.

To provide adequate direction to healthcare providers, a resident should list his instructions as specifically as possible. If an agent is appointed, those instructions also can provide additional guidance to the agent.

**An AHCD enables a resident to state his preferences regarding future health care even if the resident has no agent specified.**

Examples of Healthcare Decisions

An AHCD allows an agent to make all healthcare and treatment decisions for an incapacitated resident, subject to the resident’s instructions in the AHCD. Typically the agent can make any of these decisions:

- Consent or refuse to consent to any care, treatment, service, or procedure, including diagnostic tests, medications, and surgery
- Select or discharge health care providers
- Decide whether to provide, withhold, or withdraw life-sustaining procedures
- Authorize an autopsy
- Direct disposition of remains such as burial, cremation, or anatomical gifts

**TO LEARN MORE**

An agent may not consent to the commitment or placement of a resident in a mental health treatment facility or to convulsive treatment or psychosurgery.

**Health care agents can decide whether to provide, withhold, or withdraw life-sustaining procedures for incapacitated residents.**

**Comparison: Power of Attorney for Health Care versus Individual Health Care Instruction**

An AHCD generally consists of a Power of Attorney for Health Care document and an Individual Health Care Instruction. However, the Power of Attorney for Health Care and the Individual Health Care Instruction serve different purposes and, if possible, residents should complete both.

In general, a Power of Attorney for Health Care allows a resident to appoint an individual to act on the resident’s behalf in making healthcare decisions when the resident is unable to do so. An Individual Health Care Instruction allows the resident to specify preferences about future health care for his agent and healthcare providers.

When possible, residents should use a Power of Attorney for Health Care to appoint an agent, because the agent can make decisions based on the particular circumstances. By contrast, it is extremely difficult for a resident to give meaningful instructions for every healthcare decision that may arise in the future.

**ASK THE EXPERTS—DO-IT-YOURSELF AHCDS**

**Do I need to hire an attorney to prepare an Advance Health Care Directive?**

Not necessarily. Although attorneys can prepare an AHCD, the document can also be completed using a free or inexpensive fill-in-the-blank form. For residents whose desires are relatively straightforward, these form documents generally are adequate and simple to complete.

California does not require residents to use any particular AHCD form. However, because each state has its own laws governing advance directives, California residents should be sure to use forms that comply with California law. You can find a sample Advance Health Care Directive in California Probate Code section 4701, online at www.ag.ca.gov (search: “Probate Code Advanced Health Care”). There also are acceptable forms on many other websites available at little or no cost, including the following:

- Bet Tzedek Legal Services: www.bettzedek.org/resources, (323) 939-0506
- California Medical Association: www.cmanet.org (search: “advance health care directive”), (800) 882-1262
An Individual Health Care Instruction can provide guidance to a resident’s agent and healthcare providers. It is most useful, however, for residents who do not have a family member or friend who is able or willing to act as agent. Under those circumstances, an Individual Health Care Instruction may be the resident’s only option.

**AHCD Requirements**

To be valid, an AHCD must be signed by a competent person age 18 or older; contain the person’s name, signature, and date of signature; and be notarized or witnessed by two qualified adults. If the AHCD is being signed by a nursing home resident, it must also be witnessed by a representative of the Ombudsman Program, either as one of the adult witnesses or in addition to the notarization.

Neither the agent, the resident’s physician, nor an owner or employee of the nursing home may serve as a witness. At least one of the two witnesses must be someone who is not related to the resident nor entitled to any of the resident’s property after the resident’s death.

**Changing an AHCD**

If properly completed, an AHCD remains effective indefinitely. If a resident is of sound mind, he can change or revoke an AHCD at any time. A new AHCD, properly completed, will automatically revoke the old form.

This guide recommends that all changes or revocations be completed in writing. The resident should notify the former and new healthcare agents (if applicable), complete a new AHCD, and provide copies of the new directive to the new agent, family members, nursing home, physicians, and hospitals.

Under California law, a copy is just as valid as an original.

**AHCD Notification and Registration**

A resident who has completed an AHCD should prepare a card that lists the telephone numbers of the agent and alternate agents, and keep the card in the resident’s wallet or

---

**ASK THE EXPERTS—REQUIRING AN AHCD**

*Can my brother’s nursing home require him to sign an Advance Health Care Directive?*

No, it cannot. Federal and state laws prohibit nursing homes from requiring a resident to sign an Advance Health Care Directive or other directive for health care as a condition for admission to or continued stay in the facility.

In addition, a nursing home must inform incoming residents of their right to accept or refuse medical treatment and their option to create an AHCD or other type of healthcare directive. If a resident chooses to create any type of advance directive, the nursing home must document that choice in the resident’s medical record.
purse. If desired, the resident can register the AHCD with the California Secretary of State by calling (916) 653-3984, or visiting www.sos.ca.gov/ahcdr.

**TIP:** A resident should make several copies of his AHCD and distribute it to family, friends, HMOs, physicians, nursing homes, hospitals, and other healthcare personnel and facilities where the resident receives medical care.

**Nursing Homes’ Obligation to Comply with AHCDs**

Nursing homes are required to obey the resident’s instructions in an Individual Health Care Instruction or decisions of an agent appointed under a Power of Attorney for Health Care. There are three rare exceptions to that rule.

Nursing homes are not required to obey a request for health care if that health care is:

- Medically ineffective
- Contrary to generally accepted healthcare standards, or
- Contrary to a conscience-based policy of the nursing home (A nursing home must give its residents or their authorized agents clear advance notice of any conscience-based policies that may affect the provision of care.)

If a nursing home or other healthcare provider refuses to obey an appropriate decision or instruction of the resident, and if none of the three 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.

**Nursing homes are required to obey the resident’s instructions in an Individual Health Care Instruction or decisions of an agent appointed under a Power of Attorney for Health Care.**

[ASK THE EXPERTS—REFUSAL OF MEDICAL TREATMENT]

**My sister is my father’s healthcare agent. What happens if she decides to accept or refuse medical treatment and my dad objects?**

If the agent under an AHCD, in this case your sister, provides instructions regarding a resident’s health care, and the resident—your dad—objects to those instructions, the nursing home or other healthcare provider is not authorized to comply with the agent’s instructions. A nursing home must comply with a resident’s healthcare wishes, and proceed as if there were no AHCD.

Nursing homes and other healthcare providers who choose not to comply with a resident’s or an agent’s instructions are required to take the following steps:

- Promptly notify the resident or agent.
• Assist in transferring the resident to another healthcare provider willing to comply with the instructions, unless the resident refuses the assistance.

• Continue to provide care, including pain relief and palliative care, until the transfer is accomplished or it becomes apparent that no such transfer is possible.

Conservatorships
When a difficult healthcare decision needs to be made for an incapacitated resident who never appointed an agent, or when family members and friends of such a resident disagree on the proper medical treatment, a family member or friend should seek formal, documented authority to make healthcare decisions on behalf of the resident.

That individual can ask a court to be appointed conservator over the resident or to be given authority to make a particular healthcare decision for the resident. In a conservatorship, a court appoints someone to act indefinitely on behalf of an incapacitated adult. The conservator can be given the power to determine medical treatment, place of residence, and/or finances of the incapacitated adult, called the conservatee.

In a conservatorship, a court appoints someone to act indefinitely on behalf of an incapacitated adult.

The court determines the scope of a conservator’s powers. Conservators are not authorized to make healthcare decisions on behalf of a conservatee unless two conditions are met. First, the court must determine that the conservatee lacks the capacity to give an informed consent for medical treatment. Second, the court must order that the conservator be given the power to make healthcare decisions for the conservatee. Conservators may not place a resident in a locked facility unless they receive special court approval.

If an incapacitated resident does not need a conservator indefinitely, a family member,
Making Healthcare Decisions

friend, or other interested person can ask, or petition, the court for authority over a particular healthcare decision for the resident. Unlike a conservatorship, this procedure does not grant the petitioner authority over the resident’s place of residence or finances. In addition, the authority of the petitioner expires at the conclusion of that particular healthcare treatment.

Conservators may not place a resident in a locked facility unless they receive special court approval.

Anyone interested in becoming a conservator or gaining a particular healthcare authorization on behalf of a resident should consult an attorney.

Comparison: AHCD versus Conservatorship

If available, an Advance Health Care Directive is better than a conservatorship because it allows a resident, rather than the Court, to control future healthcare decisions. In an AHCD, a resident can appoint an agent to make decisions for him if he should become incapacitated, and can also state his preferences regarding future health care, such as whether to authorize life-sustaining treatment.

If a resident has never completed an AHCD and becomes incapacitated, a conservatorship may be necessary. Unlike an AHCD, a conservatorship involves a legal proceeding, is costly, and generally takes longer than two months to complete. In a conservatorship, the judge appoints the conservator and decides

ASK THE EXPERTS — WHAT IF A RESIDENT HAS NO HEALTHCARE AGENT OR FAMILY MEMBERS?

Who makes health care decisions for an incapacitated nursing home resident who has no family members or friends willing to act as a legal representative?

In California, each county’s Public Guardian Office can act as conservator for an incapacitated resident, though most Public Guardian Offices accept relatively few conservatorship cases. A private, professional conservator also may be appointed to act on behalf of the resident. In addition, any interested person, including a resident’s healthcare provider, can apply to the court for authorization for a specific healthcare decision.

California law authorizes interdisciplinary teams in nursing homes to make healthcare decisions for incapacitated residents with no legal representative. These interdisciplinary teams are made up of the resident’s physician, appropriate members of the nursing home staff, and, if possible, a family member or friend of the resident. The team must attempt to make decisions consistent with the resident’s desires. However, the team has legal authority to make only relatively routine medical decisions. In particular, this team cannot order the withholding or withdrawal of life-sustaining treatment.
what types of decisions the conservator can make. An appointed conservator might not have any knowledge about the resident’s healthcare preferences.

The Right to Die
Under California law, residents may choose to make healthcare decisions that likely will hasten their death. Adults who can make their own decisions have the right to accept or refuse medical treatment or life-sustaining procedures. That includes, for example, the right to refuse artificial nutrition through a feeding tube or hydration through intravenous fluids.

To make sure that residents’ wishes regarding life-sustaining treatment are followed, residents should express their wishes in these documents commonly recognized by healthcare providers:

- AHCDs
- Do Not Resuscitate Forms
- Physician Orders for Life-Sustaining Treatment (POLST)

*Under California law, residents may choose to make healthcare decisions that likely will hasten their death.*

Do Not Resuscitate Orders
Residents who wish to authorize healthcare providers to withhold resuscitative measures such as cardiopulmonary resuscitation (CPR) must complete a written document. The law requires that such a document, commonly referred to as a *Do Not Resuscitate* (DNR) order, must also be signed by a physician. Neither witnesses nor notarizations are required.

ASK THE EXPERTS — PARAMEDICS AND DNR ORDERS

*My wife has an AHCD on file with her nursing home that says she does not want CPR, but I’ve heard stories about paramedics trying to resuscitate dying residents even though they have completed legal documents expressing their wishes. Can they do that?*

Yes, they can, unless they have been shown that your wife has signed a DNR form or is wearing a “Do Not Resuscitate” bracelet or medallion approved by a paramedic agency.

Like all healthcare providers, paramedics are obligated to honor AHCDs, POLST forms, DNR orders, and other similar documents. Keep in mind, though, that paramedics provide emergency medical care and generally do not have time to evaluate residents’ advance directive forms.

Residents with a DNR order typically choose not to receive any of a number of so-called heroic measures, including the following:

- CPR
- Defibrillation (electric shocks to the heart)
• Mechanical ventilation (assisted breathing using mechanical devices)
• Medications such as adrenalin given to start the heart beating again if it stops

**Effect on Other Medical Treatments**
DNR orders apply only when the heartbeat or breathing stops. They do not affect other treatments given before the heartbeat or breathing has stopped. Residents with DNR orders receive full treatment for pain, shortness of breath, bleeding, or blockages of the airways.

**Reversing a DNR Order**
A resident can reverse a DNR order at any time. A resident who wishes to receive full treatment, such as CPR or defibrillation, should ask his healthcare provider and family to destroy all copies of the DNR order. A resident with a DNR order who wishes to receive full treatment may inform paramedics and other emergency medical personnel to ignore the DNR order, but communicating that wish in the midst of a medical emergency might be difficult or impossible.

DNR orders and AHCDs can both instruct healthcare providers to withhold resuscitative measures. However, the DNR form is the only advance directive form routinely honored by emergency medical personnel.

*A resident can reverse a Do Not Resuscitate order at any time.*

**TO LEARN MORE**
DNR forms may be obtained from a physician’s office, hospital, nursing home, or the California Emergency Medical Services Authority (CEMSA). A free DNR form may be obtained from the CEMSA website at www.emsa.ca.gov (search: “dnr form”) or by calling (916) 322-4336.

Do Not Resuscitate bracelets and medallions may be obtained from the MedicAlert Foundation: www.medicalert.org, (888) 633-4298.

These forms, bracelets, and medallions are honored by paramedics throughout California.

**Hospital DNR Orders**
The vast majority of printed DNR forms are entitled *Pre-Hospital Do Not Resuscitate (DNR) Form*. These forms are typically used in non-hospital settings such as an individual’s home or nursing home.

As a result, many hospitals may not be familiar with pre-hospital DNR forms. On admission to a hospital, residents who do not want resuscitative measures should discuss their wishes with the attending physician as soon as possible, so that the physician can issue the appropriate in-hospital DNR order.
Living Wills and DNR Orders
Some people list their healthcare desires by using documents not recognized by law. For example, many people complete a document commonly called a living will. These documents list a preference to receive or not receive life-sustaining medical treatment under certain circumstances.

Individuals with a living will should complete an AHCD, a POLST form, and/or a DNR form, as appropriate.

Physician Orders for Life-Sustaining Treatment
A Physician Orders for Life-Sustaining Treatment (POLST) form is a document that converts an individual’s wishes about life-sustaining measures and resuscitation into physician orders, which can then be acted on immediately by healthcare providers. POLST forms are intended to help seriously ill individuals and healthcare professionals discuss, develop, and implement care plans that reflect the individual’s wishes.

The POLST form is a standardized form that must be signed by the individual and his physician. If the individual lacks decision-making capability, the individual’s legal representative can sign the form in his place. POLST forms can be revised or revoked at any time by the individual or, if the individual lacks capacity, by his legal representative.

Because a POLST form is a physician’s order, it is supposed to be honored and recognized by healthcare providers everywhere, regardless of whether an individual is in the hospital, at home, or in a nursing home. Residents are not required to complete POLST forms. However, if a resident does complete a POLST form, healthcare providers are required to treat the resident in accordance with his wishes unless the form requires medically ineffective care or care contrary to generally accepted standards.

**POLST forms are supposed to be honored by healthcare providers everywhere, regardless of whether an individual is in the hospital, at home, or in a nursing home.**

Comparison: POLST versus AHCD versus DNR
POLST forms are intended to complement but not replace an Advance Health Care Directive. AHCDs allow individuals to appoint an agent to speak on their behalf should they become unable to speak for themselves. They also set forth specific wishes about future health care. AHCDs provide a broad outline of an individual’s wishes for end-of-life care and may be filled out by any adult, regardless of health condition. AHCDs are not physician orders, however, and may not be available when needed.

In contrast, POLST forms are designed for seriously ill individuals to identify their specific wishes on key medical decisions. Additionally, a POLST form is a physician order and is designed to travel with an individual from one treatment facility to another.
POLST forms also differ from a DNR in significant ways. A DNR addresses only the decision to forgo resuscitation. A POLST form, however, addresses a range of life-sustaining measures and allows a person to choose treatment or forgo it, as he sees fit.

TO LEARN MORE
POLST forms and additional information may be obtained from the Coalition for Compassionate Care of California at www.capolst.org or (916) 489-2222.

ASK THE EXPERTS—HALTING LIFE-SUSTAINING TREATMENT

Can an incapacitated resident be allowed to die if he didn’t execute a legal request for limited medical treatment?

Yes, he can. A court-appointed conservator or the resident’s nearest relative might have the authority to halt life-sustaining medical treatment. In addition, healthcare providers may accept informal, non-binding indications of a resident’s treatment desires. If you are trying to help an incapacitated resident in this situation, contact a knowledgeable attorney for assistance.
RESOURCES
For more information on topics in this chapter, consult the following agencies, online resources, and the legal citations on which the information is based.

Agencies

• Bet Tzedek Legal Services: www.bettzedek.org, (323) 939-0506
• California Advocates for Nursing Home Reform: www.canhr.org, (800) 474-1116
• California Department of Public Health, Licensing and Certification Division: www.cdph.ca.gov/programs/LnC, (800) 236-9747. (For phone numbers of local District Offices, see Appendix C, pages 118–120.)
• California Long-Term Care Ombudsman Program: www.aging.ca.gov/programs (search: “ombudsman”), CRISIStline (800) 231-4024. (For phone numbers of local Ombudsman Programs, see Appendix B, pages 115–117.)

Print

Online
• California Emergency Medical Services Authority: www.emsa.ca.gov (search: “dnr form”), (916) 322-4336
• California Medical Association: www.cmanet.org (search: “advance health care directive”), (800) 882-1262
• California Secretary of State, Advance Health Care Directive Registry: www.sos.ca.gov/ahcdr, (916) 653-3984
• Coalition for Compassionate Care of California: www.capolst.org, (916) 489-2222
• MedicAlert Foundation: www.medicalert.org, (888) 633-4298
Legal Citations
The discussions in this chapter are based primarily on California Government Code, sections 27430 through 27436; California Health and Safety Code, section 1418.8; California Probate Code, sections 1800 through 1898, 2100 through 2808, 3200 through 3211, and 4600 through 4805; Barber v. Superior Court, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983); 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); Conservatorship of Wendland, 26 Cal. 4th 519, 110 Cal. Rptr. 2d 412 (2001); Rains v. Belshe, 32 Cal. App. 4th 157, 38 Cal. Rptr. 2d 185 (1995).
CHAPTER 8
RESOLVING PROBLEMS INVOLVING NURSING HOMES
Nursing homes are required to uphold the rights of their residents and provide them with quality care, but not all nursing homes do so. In determining how to resolve a problem with a facility, residents should consider the nature of the problem and their comfort level in discussing it with others.

For example, a resident may feel comfortable talking about her lost dentures with nursing home staff but prefer that a family member or ombudsman handle issues involving neglect or abuse. This chapter suggests strategies for ensuring that nursing homes comply with the law and provide the care that nursing home residents deserve.

**Informal Problem Resolution**

A resident who is having problems at a nursing home should first discuss her concerns with nursing home staff. If the problem involves medical care, the resident should talk to the nurse or nursing assistant on duty. If the problem persists, the resident should talk to a supervisor, generally the director of nursing or nursing home administrator. If necessary, the resident should request a care plan meeting. For non-medical problems, the resident should talk to the appropriate staff member (or supervisor) such as the cook, social worker, or activity director.

When discussing the problem, the resident should listen carefully to the nursing home’s position. Many problems can be resolved through discussion and negotiation if the resident and nursing home are willing to listen to each other and work towards a solution.

Whenever possible, residents should remind the nursing home about its legal obligations. (This guide can prove valuable in these instances.) For example, nursing homes cannot refuse to perform a service required by law such as providing assistance with eating or bathing. If nursing homes are not following the law, residents should insist that they do so.

**TIP:** Nursing homes, like residents, enjoy positive feedback. If you are receiving good care, be sure to tell the staff member and her supervisor. Positive relationships with staff may result in better care and provide an advocate if problems arise. If you are not receiving good care, you should tell the staff member and, if necessary, the supervisor. If you do not speak up, your problem is unlikely to get better. In addition, the same thing may happen to you again or to other residents.
Resident Councils
Residents working together as a group can sometimes resolve problems individual residents cannot resolve on their own. Nursing home residents have the right to organize and participate in resident councils. Resident councils may also include, if invited by the group, family members, advocates, representatives of the Ombudsman Program, and nursing home staff. A nursing home must provide the resident council with a private meeting space.

Recommendations made by a resident council must be reviewed and acted on by the nursing home.

Family Councils
Family members and friends can organize a family council to discuss and address concerns of their loved ones and advocate for better care. If a nursing home does not have a family council, a resident or family member should contact the Ombudsman Program for assistance in forming one.

Family councils can be powerful instruments of change, because they require nursing homes to address and respond to group concerns. They also can serve as educational forums for the exchange of information.

Nursing homes must allow family councils to meet regularly outside the presence of nursing home employees. If requested, the nursing home must provide family councils with a meeting room and a prominent place to post meeting notices. The nursing home must send notices of family council meetings to residents’ family members. The nursing home must designate a staff person to provide assistance and respond to written requests that result from family council meetings. Nursing homes must respond to all such requests within 10 days.

ASK THE EXPERTS—PROBLEM-SOLVING STEPS AND RESOURCES

My husband’s nurses do not respond when he presses the call button. What should we do?

First, discuss your concerns with your husband’s nurses. If the problem does not get better, speak with the director of nursing or nursing home administrator. If that does not help, try one or more of these actions:

- Call the Ombudsman Program.
- File a complaint with the California Department of Public Health.
- Contact your California Assembly Member (www.assembly.ca.gov) or State Senator (http://senate.ca.gov).
- Consult an attorney knowledgeable about nursing homes.

(For phone numbers of local Ombudsman Programs and California Department of Public Health District Offices, see Appendices B and C, pages 115–120.)
Ombudsman Program
Sometimes residents cannot resolve an issue by discussing it with nursing home staff. Residents then may wish to call the local Ombudsman Program for assistance.

All nursing homes are required to post, in a noticeable location, phone numbers for the local Ombudsman office and the Statewide CRISISline at (800) 231-4024. The CRISISline is available 24 hours a day, 7 days a week, to take calls and refer complaints from residents.

Advocating for Consumers
The Ombudsman Program, established by federal and state laws, provides free assistance to nursing home residents. An “Ombudsman” is a consumer advocate who investigates complaints and helps resolve them. Ombudsmen include trained professional staff and community volunteers, and are completely independent from the nursing home.

Ombudsmen help to ensure that problems of nursing home residents are addressed and that residents’ rights are protected. If an Ombudsman is unable to resolve the problem, residents may request that the Ombudsman file a complaint on the resident’s behalf with the California Department of Public Health.

Confidentiality
Residents reporting a problem to the Ombudsman Program can keep their names confidential. Residents can also decide whether to participate in discussions between the Ombudsman and the nursing home regarding their problems. In almost all instances, it is better to allow the Ombudsman to reveal residents’ names. It is extremely difficult to resolve most issues anonymously.

TIP: 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 assisted living facilities. (See California Ombudsman Program Phone Numbers, Appendix B, pages 115–117.)

Government Agencies
Residents who do not receive satisfactory
results by talking with nursing home staff may wish to contact the California Department of Public Health’s Licensing and Certification Division, which licenses, inspects, and regulates all nursing homes in California. (For phone numbers of local District Offices, see Appendix C, pages 118–120.)

Residents or interested individuals can make an oral or written complaint to the California Department of Public Health (CDPH) about any nursing home in California. Individuals who file a complaint by telephone should follow up in writing to make sure that the inspector assigned to the case understands the problem and has copies of necessary documents.

Written complaints should describe all relevant information in a well-organized manner. A person may choose to make her complaint anonymously. However, anonymous complaints are generally more difficult to resolve.

**TIP:** For additional information about filing a complaint, see the fact sheet “How to File a Complaint” prepared by the California Advocates for Nursing Home Reform at www.canhr.org/factsheets.

**Investigations**
The CDPH must assign an inspector to make a preliminary review of each complaint. It must then notify the individual making the complaint of the name of the inspector within two working days of the complaint being filed. The CDPH must also conduct an investigation at the nursing home, generally within ten working days. On request, the person making the complaint may have the option of attending the inspection.

After investigating a complaint, the CDPH may take any of the following actions:

- Force the nursing home to fix a problem and also pay a monetary penalty to the CDPH.
- Force the nursing home to fix a problem.
- Decide that the nursing home has broken no law.

If the CDPH decides that the nursing home must fix a problem, the facility must file a plan of correction.

---

**ASK THE EXPERTS—PROTECTING THE RESIDENT WHO FILES A COMPLAINT**

*If I file a complaint against my nursing home, won’t it retaliate against me?*

It is unlawful for a nursing home to retaliate against a resident for making a complaint to the California Department of Public Health. More importantly, if you do not force the nursing home to provide you with good care, you will continue to get poor care. Squeaky wheels do get the grease.
Follow-Up
Whatever action is taken, the CDPH must report its decision to the person making the complaint. That individual can request an informal conference to appeal the decision if she feels that the CDPH acted improperly or weakly.

The CDPH must inform the person who filed the complaint of the proposed plan of action and provide a written report of its findings within 10 working days of the completion of its investigation.

Filing a Lawsuit
Residents or family members may file a lawsuit against a nursing home to force the nursing home to comply with the law. For example, a personal injury action may be appropriate if a nursing home’s action or inaction has caused serious physical or emotional harm to a resident.

Similarly, if a nursing home has violated certain rights of the resident, the resident or the resident’s representative can sue the nursing home to obtain:

• Changes in the nursing home’s practices
• Up to $500 per violation per day
• Payment of attorneys’ fees

These kinds of lawsuits can help a resident force a nursing home to fix conditions that, though not immediately life-threatening, are dangerous or harmful to the resident.

In addition, if a resident can show that a nursing home regularly committed unlawful or unfair acts and that the resident has been injured, she could file a lawsuit against the nursing home’s unfair business practices. In such a lawsuit, the resident could obtain a court order that would force the nursing home to improve its way of doing business.

TIP: Lawsuits against nursing homes are subject to statutory deadlines. Any resident considering strategies that involve lawsuits should consult an attorney experienced in these matters immediately.

ASK THE EXPERTS—FILING A COMPLAINT WITH THE BUREAU OF MEDI-CAL FRAUD & ELDER ABUSE

My dad is on Medi-Cal, and his nursing home is billing him for services he never received. The nursing home won’t take the charges off the bill, and the California Department of Public Health investigated my complaint and found it “unsubstantiated.” What should I do?

File a complaint with the Bureau of Medi-Cal Fraud & Elder Abuse (BMFEA) at (800) 722-0432. The BMFEA, a division of the California Attorney General’s Office, investigates and prosecutes complaints involving serious neglect, abuse, or Medi-Cal fraud of nursing home residents.
Elder and Dependent Adult Abuse

Elder abuse is the neglect, exploitation, or other mistreatment of anyone age 65 or older that results in physical harm or mental suffering. Dependent Adult abuse is the mistreatment of a person between 18 and 64 years old with a physical or mental disability that restricts that person’s ability to carry out everyday activities. Such abuse can involve physical violence, emotional abuse, abduction, isolation, or abandonment. It also could involve the unlawful taking of money or property.

If a person suspects that a nursing home resident is the victim of mental, physical, or financial abuse, the suspected abuse should be reported to the Ombudsman Program or a local law enforcement agency. Nursing home staff and other mandated reporters, such as nurses, physicians, and social workers, must also report all cases of known or reasonably-suspected abuse of nursing home residents.
RESOURCES
For more information on topics in this chapter, consult the following agencies, online and other electronic resources, and the legal citations on which the information is based.

Agencies
• Bet Tzedek Legal Services: www.bettzedek.org, (323) 939-0506
• Bureau of Medi-Cal Fraud & Elder Abuse (BMFEA): www.ag.ca.gov/bmfea, (800) 722-0432
• California Advocates for Nursing Home Reform: www.canhr.org, (800) 474-1116
• California Department of Public Health, Licensing and Certification Division: www.cdph.ca.gov/programs/LnC, (800) 236-9747. (For phone numbers of local District Offices, see Appendix C, pages 118–120.)
• California Long-Term Care Ombudsman Program: www.aging.ca.gov/programs (search: “ombudsman”), CRISISline (800) 231-4024. (For phone numbers of local Ombudsman Programs, see Appendix B, pages 115–117.)

Online
• California Advocates for Nursing Home Reform Fact Sheet, “Family Councils”: www.canhr.org/factsheets
• California Advocates for Nursing Home Reform Fact Sheet, “How to File a Complaint Against a Nursing Home”: www.canhr.org/factsheets
• California Advocates for Nursing Home Reform, “Organizing Family Councils in Long-Term Care Facilities”: www.canhr.org (search: “organizing family councils”)

Other Electronic
• California Advocates for Nursing Home Reform, “Family Councils: Making a Difference,” DVD: www.canhr.org (search: “family council dvd”)

Legal Citations
The discussions in this chapter are based primarily on Title 42 of the United States Code, section 3027(a); California Business and Professions Code, sections 17200 through 17209; California Health and Safety Code, sections 1418.2, 1418.4, 1419, 1420, 1424 and 1430; California Probate Code, section 2356.5; California Welfare and Institutions Code, sections 9700 through 9741, and 15600-15657.7; and Title 22 of the California Code of Regulations, sections 8010 through 8045.
APPENDIX A
NURSING HOME CHECKLIST

For updates to this checklist, please visit Bet Tzedek at www.bettzedek.org/resources.

Residents

☐ Are the residents’ clothes clean?

☐ Are the residents dressed appropriately for the time of day and for the season of the year?

☐ Are the residents clean-shaven? Is their hair combed? Are their nails clipped?

Residents’ Rooms

☐ Are the resident rooms clean?

☐ Is the temperature comfortable?

☐ Do the rooms have good ventilation, air conditioning, and individual thermostats?

☐ Is there space for personal items?

☐ Have residents decorated their rooms?

☐ Are private baths and showers provided?

☐ Are bathrooms easily accessible for wheelchairs?

☐ Do bathrooms have grab bars near toilets and bathtubs?

☐ Is there adequate closet space?

☐ Can possessions be kept secure?

☐ Is a private phone available?

☐ Are call buttons within easy reach from the bed and bathroom?

☐ Is cable television available?

Staff

☐ Do employees know residents by name?

☐ Do employees show respect to the residents?

☐ Does the staff appear to have enough time to care for residents, or are they frantically running from one task to another?

☐ Is the administrator open to your questions and requests?

☐ Is the facility staff receptive to making accommodations for a resident’s individual wants or needs? For example, are residents given a say in the selection of a roommate?

☐ How long have most staff members been working at the facility?

☐ For how many hours per day is a registered nurse present at the facility? For how many hours per day is a licensed nurse present?
Are nurse aides assigned so that they generally work with the same residents each day?

Services and Programs

Are social work services performed by a licensed social worker or by a minimally trained social services designee?

Does the home have a resident council or family council?

Are special events or holiday parties held for the residents?

Are religious services offered at the facility?

Is transportation available for residents who want to participate in social, religious, or community activities outside the facility? Is this transportation wheelchair-accessible?

Does the facility organize activities and field trips that take into account residents’ interests?

Does the facility have private areas for residents to meet with family, visitors, or doctors?

Will the staff provide individualized services for the person seeking nursing facility care? If so, can the administrator or Director of Nurses explain how the services will be provided and how the facility will ensure that the services actually are provided?

Can the facility provide physical therapy, speech therapy, or occupational therapy?

Look at the facility schedule for the month. Is there any variety? Are there any activities that would be of interest to the individual seeking nursing home care?

Prevalence of Restraints

How many of the residents are tied up in a bed or chair?

Do residents seem over-medicated?

Food

Are the dining room and kitchen areas clean?

Are there unpleasant odors?

Is the staff patient in assisting residents who can’t feed themselves?

Does the food taste, smell, and look appetizing?

How much choice do residents have in the food they are served?

Will the home provide special diets, such as low cholesterol or low salt?

Ask the staff for food the prospective resident prefers. How do the staff members respond?
Look at the menu for the month. Is there variety in the menu, or are a few meals served over and over again?

How is food made available between mealtimes?

**Physical Surroundings**

- Is the facility quiet or noisy?
- Does the facility have a safe outside area?
- Does the facility have a specific room for therapy services?

**Location**

- Is the facility accessible for the prospective resident’s family members and friends?
- Is the facility close to the prospective resident’s neighborhood?

**Opinions of Others**

- What do current residents say about the facility? What do their family members and friends say?
- Does the prospective resident’s physician have an opinion about the facility? Is the prospective resident’s physician willing to visit the resident at the facility?

**Payment**

- Is the facility certified to accept reimbursement from either Medicare or Medi-Cal?
- Does the facility have a relationship with the resident’s health maintenance organization (HMO)?
- What is the daily rate?
- What “extra” charges are not included in the daily rate?
- Is a deposit required? (Remember, a deposit can’t be required if the resident’s care will be covered by Medicare or Medi-Cal).

**Public Records**

- Are inspection reports easily accessible from the facility?
- How many violations have been found by the California Department of Public Health? What kind of violations were they?
- Has the facility been fined for violations?
- Has the facility been threatened with loss of its license or loss of its federal certification?
- Have any lawsuits been filed against the facility?
### APPENDIX B
CALIFORNIA OMBUDSMAN PROGRAM PHONE NUMBERS

**Statewide 24-Hour CRISISLine:** (800) 231-4024  
**Office of the State Long-Term Care Ombudsman:** (916) 419-7510 or (916) 419-7511

For updates to the telephone numbers of the California Ombudsman Program, please visit Bet Tzedek at www.bettzedek.org/resources.

<table>
<thead>
<tr>
<th>County</th>
<th>Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alameda</td>
<td>(510) 638-6878</td>
</tr>
<tr>
<td>Alpine</td>
<td>(209) 532-7632</td>
</tr>
<tr>
<td>Amador</td>
<td>(209) 532-7632</td>
</tr>
<tr>
<td>Butte</td>
<td>(530) 898-5923</td>
</tr>
<tr>
<td></td>
<td>(800) 822-0109</td>
</tr>
<tr>
<td>Calaveras</td>
<td>(209) 532-7632</td>
</tr>
<tr>
<td>Colusa</td>
<td>(530) 898-5923</td>
</tr>
<tr>
<td></td>
<td>(800) 822-0109</td>
</tr>
<tr>
<td>Contra Costa</td>
<td>(925) 685-2070</td>
</tr>
<tr>
<td>Del Norte</td>
<td>(707) 269-1330</td>
</tr>
<tr>
<td>El Dorado</td>
<td>(530) 642-4860</td>
</tr>
<tr>
<td>Fresno</td>
<td>(559) 224-9177</td>
</tr>
<tr>
<td>Glenn</td>
<td>(530) 898-5923</td>
</tr>
<tr>
<td></td>
<td>(800) 822-0109</td>
</tr>
<tr>
<td>Humboldt</td>
<td>(707) 269-1330</td>
</tr>
<tr>
<td>Imperial</td>
<td>(760) 339-6457</td>
</tr>
<tr>
<td>Inyo</td>
<td>(760) 872-4128</td>
</tr>
<tr>
<td>Kern</td>
<td>(661) 323-7884</td>
</tr>
<tr>
<td></td>
<td>(888) 292-4252, Ext. 1109</td>
</tr>
<tr>
<td>Kings</td>
<td>(559) 582-3211, Ext. 2824</td>
</tr>
<tr>
<td></td>
<td>(559) 583-0333</td>
</tr>
<tr>
<td>Lake</td>
<td>(707) 467-5835</td>
</tr>
<tr>
<td></td>
<td>(800) 997-3675</td>
</tr>
<tr>
<td>Lassen</td>
<td>(530) 229-1435</td>
</tr>
<tr>
<td></td>
<td>(530) 229-1816</td>
</tr>
<tr>
<td></td>
<td>(866) 699-6191</td>
</tr>
<tr>
<td>Los Angeles</td>
<td>(310) 393-3618</td>
</tr>
<tr>
<td></td>
<td>(800) 334-9473</td>
</tr>
<tr>
<td>Canoga Park</td>
<td>(818) 444-0315</td>
</tr>
<tr>
<td>Lakewood</td>
<td>(562) 925-2346</td>
</tr>
<tr>
<td>Los Angeles</td>
<td>(213) 617-8957</td>
</tr>
<tr>
<td>Pasadena</td>
<td>(626) 793-3510</td>
</tr>
<tr>
<td>Santa Monica</td>
<td>(310) 899-1483</td>
</tr>
<tr>
<td>Madera</td>
<td>(559) 224-9177</td>
</tr>
<tr>
<td>Marin</td>
<td>(415) 473-7446</td>
</tr>
<tr>
<td>Mariposa</td>
<td>(209) 532-7632</td>
</tr>
<tr>
<td>Mendocino</td>
<td>(707) 467-5835</td>
</tr>
<tr>
<td></td>
<td>(800) 997-3675</td>
</tr>
<tr>
<td>Merced</td>
<td>(209) 385-7402</td>
</tr>
<tr>
<td>County</td>
<td>Telephone</td>
</tr>
<tr>
<td>--------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Modoc</td>
<td>(530) 229-1435</td>
</tr>
<tr>
<td></td>
<td>(530) 229-1816</td>
</tr>
<tr>
<td></td>
<td>(866) 699-6191</td>
</tr>
<tr>
<td>Mono</td>
<td>(760) 872-4128</td>
</tr>
<tr>
<td>Monterey</td>
<td>(831) 655-1334</td>
</tr>
<tr>
<td>Salinas</td>
<td>(831) 758-4011</td>
</tr>
<tr>
<td>Napa</td>
<td>(707) 255-4236</td>
</tr>
<tr>
<td>Nevada</td>
<td>(916) 376-8910</td>
</tr>
<tr>
<td></td>
<td>(530) 274-2825</td>
</tr>
<tr>
<td>Orange</td>
<td>(714) 479-0107</td>
</tr>
<tr>
<td>Local Access</td>
<td>(800) 300-6222</td>
</tr>
<tr>
<td>Placer</td>
<td>(916) 376-8910</td>
</tr>
<tr>
<td></td>
<td>(530) 823-8422</td>
</tr>
<tr>
<td>Plumas</td>
<td>(530) 898-5923</td>
</tr>
<tr>
<td></td>
<td>(800) 822-0109</td>
</tr>
<tr>
<td>Riverside</td>
<td>(951) 686-4402</td>
</tr>
<tr>
<td></td>
<td>(877) 430-4433</td>
</tr>
<tr>
<td>Hemet</td>
<td>(951) 929-0196</td>
</tr>
<tr>
<td>Palm Springs</td>
<td>(760) 328-9139</td>
</tr>
<tr>
<td>Sacramento</td>
<td>(916) 376-8910</td>
</tr>
<tr>
<td>San Benito</td>
<td>(831) 429-1913</td>
</tr>
<tr>
<td>San Bernardino</td>
<td>(909) 891-3928</td>
</tr>
<tr>
<td></td>
<td>(866) 229-0284</td>
</tr>
<tr>
<td>Ontario</td>
<td>(909) 948-6217</td>
</tr>
<tr>
<td>Redlands-Yucaipa</td>
<td>(909) 891-3906</td>
</tr>
<tr>
<td>San Bernardino</td>
<td>(909) 891-3911</td>
</tr>
<tr>
<td>Victorville</td>
<td>(760) 843-5116</td>
</tr>
<tr>
<td>Yucca Valley</td>
<td>(760) 228-5387</td>
</tr>
<tr>
<td>San Diego</td>
<td>(858) 560-2507</td>
</tr>
<tr>
<td>Local Access</td>
<td>(800) 640-4661</td>
</tr>
<tr>
<td>San Francisco</td>
<td>(415) 751-9788</td>
</tr>
<tr>
<td>San Joaquin</td>
<td>(209) 468-3785</td>
</tr>
<tr>
<td>San Luis Obispo</td>
<td>(805) 785-0132</td>
</tr>
<tr>
<td>San Mateo</td>
<td>(650) 780-5707</td>
</tr>
<tr>
<td>Santa Barbara</td>
<td>(805) 785-0132</td>
</tr>
<tr>
<td>Santa Clara</td>
<td>(408) 944-0567</td>
</tr>
<tr>
<td>Santa Cruz</td>
<td>(831) 429-1913</td>
</tr>
<tr>
<td>Shasta</td>
<td>(530) 229-1435</td>
</tr>
<tr>
<td></td>
<td>(530) 229-1816</td>
</tr>
<tr>
<td></td>
<td>(866) 699-6191</td>
</tr>
<tr>
<td>Sierra</td>
<td>(916) 376-8910</td>
</tr>
<tr>
<td></td>
<td>(530) 274-2825</td>
</tr>
<tr>
<td>County</td>
<td>Telephone</td>
</tr>
<tr>
<td>------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>Siskiyou</td>
<td>(530) 229-1435</td>
</tr>
<tr>
<td></td>
<td>(530) 229-1816</td>
</tr>
<tr>
<td></td>
<td>(866) 699-6191</td>
</tr>
<tr>
<td>Solano</td>
<td>(707) 644-4194</td>
</tr>
<tr>
<td></td>
<td>(800) 644-4194</td>
</tr>
<tr>
<td>Sonoma</td>
<td>(707) 526-4108</td>
</tr>
<tr>
<td>Stanislaus</td>
<td>(209) 529-3784</td>
</tr>
<tr>
<td>Sutter</td>
<td>(916) 376-8910</td>
</tr>
<tr>
<td></td>
<td>(530) 755-2018</td>
</tr>
<tr>
<td>Tehama</td>
<td>(530) 898-5923</td>
</tr>
<tr>
<td></td>
<td>(800) 822-0109</td>
</tr>
<tr>
<td>Trinity</td>
<td>(530) 229-1435</td>
</tr>
<tr>
<td></td>
<td>(530) 229-1816</td>
</tr>
<tr>
<td></td>
<td>(866) 699-6191</td>
</tr>
<tr>
<td>Tulare</td>
<td>(559) 582-3211, Ext. 2824</td>
</tr>
<tr>
<td></td>
<td>(800) 293-9714</td>
</tr>
<tr>
<td>Tuolumne</td>
<td>(209) 532-7632</td>
</tr>
<tr>
<td>Ventura</td>
<td>(805) 656-1986</td>
</tr>
<tr>
<td>Yolo</td>
<td>(916) 376-8910</td>
</tr>
<tr>
<td></td>
<td>(530) 668-5775</td>
</tr>
<tr>
<td>Yuba</td>
<td>(916) 376-8910</td>
</tr>
<tr>
<td></td>
<td>(530) 755-2018</td>
</tr>
</tbody>
</table>
APPENDIX C
CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
PHONE NUMBERS

Toll-Free General: (800) 236-9747  General: (916) 552-8700

For updates to the telephone numbers of the California Department of Public Health, please visit Bet Tzedek at www.bettzedek.org/resources.

<table>
<thead>
<tr>
<th>County</th>
<th>Telephone</th>
<th>County</th>
<th>Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alameda</td>
<td>(510) 620-3900</td>
<td>Humboldt</td>
<td>(707) 576-6775</td>
</tr>
<tr>
<td></td>
<td>(866) 247-9100</td>
<td></td>
<td>(866) 784-0703</td>
</tr>
<tr>
<td>Alpine</td>
<td>(916) 263-5800</td>
<td>Imperial</td>
<td>(619) 688-6190</td>
</tr>
<tr>
<td></td>
<td>(800) 554-0354</td>
<td></td>
<td>(866) 706-0759</td>
</tr>
<tr>
<td>Amador</td>
<td>(916) 263-5800</td>
<td>Inyo</td>
<td>(909) 383-4777</td>
</tr>
<tr>
<td></td>
<td>(800) 554-0354</td>
<td></td>
<td>(800) 344-2896</td>
</tr>
<tr>
<td>Butte</td>
<td>(530) 895-6711</td>
<td>Kern</td>
<td>(661) 336-0543</td>
</tr>
<tr>
<td></td>
<td>(800) 554-0350</td>
<td></td>
<td>(866) 222-1903</td>
</tr>
<tr>
<td>Calaveras</td>
<td>(916) 263-5800</td>
<td>Kings</td>
<td>(559) 437-1500</td>
</tr>
<tr>
<td></td>
<td>(800) 554-0354</td>
<td></td>
<td>(800) 554-0351</td>
</tr>
<tr>
<td>Colusa</td>
<td>(530) 895-6711</td>
<td>Lake</td>
<td>(707) 576-6775</td>
</tr>
<tr>
<td></td>
<td>(800) 554-0350</td>
<td></td>
<td>(866) 784-0703</td>
</tr>
<tr>
<td>Contra Costa</td>
<td>(510) 620-3900</td>
<td>Lassen</td>
<td>(530) 895-6711</td>
</tr>
<tr>
<td></td>
<td>(866) 247-9100</td>
<td></td>
<td>(800) 554-0350</td>
</tr>
<tr>
<td>Del Norte</td>
<td>(707) 576-6775</td>
<td>Los Angeles</td>
<td>(562) 345-6884</td>
</tr>
<tr>
<td></td>
<td>(866) 784-0703</td>
<td></td>
<td>(800) 228-1019</td>
</tr>
<tr>
<td>El Dorado</td>
<td>(916) 263-5800</td>
<td>Baldwin Park</td>
<td>(626) 430-5600</td>
</tr>
<tr>
<td></td>
<td>(800) 554-0354</td>
<td>Culver City</td>
<td>(310) 665-8400</td>
</tr>
<tr>
<td>Fresno</td>
<td>(559) 437-1500</td>
<td>El Monte</td>
<td>(626) 569-3724/3726</td>
</tr>
<tr>
<td></td>
<td>(800) 554-0351</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glenn</td>
<td>(530) 895-6711</td>
<td>Van Nuys</td>
<td>(818) 901-4375</td>
</tr>
<tr>
<td></td>
<td>(800) 554-0350</td>
<td></td>
<td></td>
</tr>
<tr>
<td>County</td>
<td>Telephone</td>
<td>County</td>
<td>Telephone</td>
</tr>
<tr>
<td>------------</td>
<td>----------------------------</td>
<td>---------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td>Madera</td>
<td>(559) 437-1500 (800) 554-0351</td>
<td>San Benito</td>
<td>(408) 277-1784 (800) 554-0348</td>
</tr>
<tr>
<td>Marin</td>
<td>(707) 576-6775 (866) 784-0703</td>
<td>San Bernardino</td>
<td>(909) 383-4777 (800) 344-2896</td>
</tr>
<tr>
<td>Mariposa</td>
<td>(559) 437-1500 (800) 554-0351</td>
<td>San Diego North</td>
<td>(619) 278-3700 (800) 824-0613</td>
</tr>
<tr>
<td>Mendocino</td>
<td>(707) 576-6775 (866) 784-0703</td>
<td>San Diego South</td>
<td>(619) 688-6190 (866) 706-0759</td>
</tr>
<tr>
<td>Merced</td>
<td>(559) 437-1500 (800) 554-0351</td>
<td>San Francisco</td>
<td>(650) 301-9971 (800) 554-0353</td>
</tr>
<tr>
<td>Modoc</td>
<td>(909) 383-4777 (800) 344-2896</td>
<td>San Joaquin</td>
<td>(916) 263-5800 (800) 554-0354</td>
</tr>
<tr>
<td>Monterey</td>
<td>(408) 277-1784 (800) 554-0348</td>
<td>San Luis Obispo</td>
<td>(805) 604-2926 (800) 547-8267</td>
</tr>
<tr>
<td>Napa</td>
<td>(707) 576-6775 (866) 784-0703</td>
<td>San Mateo</td>
<td>(650) 301-9971 (800) 554-0353</td>
</tr>
<tr>
<td>Nevada</td>
<td>(530) 895-6711 (800) 554-0350</td>
<td>Santa Barbara</td>
<td>(805) 604-2926 (800) 547-8267</td>
</tr>
<tr>
<td>Orange</td>
<td>(714) 567-2906 (800) 228-5234</td>
<td>Santa Clara</td>
<td>(650) 301-9971</td>
</tr>
<tr>
<td>Placer</td>
<td>(916) 263-5800 (800) 554-0354</td>
<td>Cupertino, Los Altos, (650) 301-9971 Mountain View, Palo Alto</td>
<td></td>
</tr>
<tr>
<td>Plumas</td>
<td>(530) 895-6711 (800) 554-0350</td>
<td>Stanford, Santa Clara, (800) 554-0353 Saratoga, Sunnyvale</td>
<td></td>
</tr>
<tr>
<td>Riverside</td>
<td>(909) 388-7170 (888) 354-9203</td>
<td>San Jose, Los Gatos, (408) 277-1784 Campbell, Milpitas</td>
<td></td>
</tr>
<tr>
<td>Sacramento</td>
<td>(916) 263-5800 (800) 554-0354</td>
<td>Morgan Hill, Gilroy (800) 554-0348</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Santa Cruz</td>
<td>(408) 277-1784 (800) 554-0348</td>
</tr>
<tr>
<td>County</td>
<td>Telephone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------</td>
<td>--------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shasta</td>
<td>(530) 895-6711</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(800) 554-0350</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sierra</td>
<td>(530) 895-6711</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(800) 554-0350</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Siskiyou</td>
<td>(530) 895-6711</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(800) 554-0350</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Solano</td>
<td>(707) 576-6775</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(866) 784-0703</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sonoma</td>
<td>(707) 576-6775</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(866) 784-0703</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stanislaus</td>
<td>(916) 263-5800</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(800) 554-0351</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sutter</td>
<td>(530) 895-6711</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(800) 554-0350</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tehama</td>
<td>(530) 895-6711</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(800) 554-0350</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trinity</td>
<td>(530) 895-6711</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(800) 554-0350</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tulare</td>
<td>(661) 336-0543</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(866) 222-1903</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuolumne</td>
<td>(916) 263-5800</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(800) 554-0354</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ventura</td>
<td>(805) 604-2926</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(800) 547-8267</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yolo</td>
<td>(916) 263-5800</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(800) 554-0354</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yuba</td>
<td>(530) 895-6711</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(800) 554-0350</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
OUR MISSION

Bet Tzedek provides free legal assistance to thousands of people who would otherwise be denied access to the legal system underpinning our democracy.

Bet Tzedek was founded in 1974 by a few individuals who sought to act upon a central tenet of Jewish law and tradition, which appears in the Bible: “Tzedek, tzedek tirdof—Justice, justice you shall pursue.” This doctrine decrees that it is the duty of all men and women to advocate the just causes of the poor and helpless.

Although Bet Tzedek remains intent on ensuring that the legal needs of the Jewish poor are met, we recognize that it is our duty to serve the entire community. For this reason, Bet Tzedek has always provided assistance to all eligible needy residents of Los Angeles County, regardless of their racial, religious or ethnic background.

Indeed, at Bet Tzedek, we believe that all of the groups in our wonderfully diverse society are strengthened when bridges are built that bring us together in a common, just cause. For the people who are Bet Tzedek—the lawyers and non-lawyers, staff members and volunteers, contributors and clients—our mission, therefore, is to pursue equal justice for all.
NURSING HOME COMPANION
An Easy-to-Use Guide to California Nursing Home Laws and Practices

BetTzedek gratefully acknowledges the City of Los Angeles Department of Aging for funding this publication.