Chapter Eight

Quality of Care in Long-Term Care Facilities

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Nursing Homes

Federal Law

In 1987, Congress passed the Nursing Home Reform Law. The Reform Law applies to every nursing home certified to accept Medicare and/or Medicaid (called "Medi-Cal" in California). Significantly, the Reform Law protects a resident of a federally-certified nursing home regardless of whether the resident is eligible for Medicare or Medicaid reimbursement, or is paying privately.

The Nursing Home Reform Law is based upon the premise that each resident deserves individualized care. A critical federal regulation (42 C.F.R. Section 483.21) states that a nursing home must provide the services that a resident needs "to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being."

Most of the discussion below is based on the Reform Law although, as indicated, some of the discussion is based on California law.

Nursing Home Falsehoods

Falsehood #1: "The nursing staff will determine the care that Ruben will receive."

This statement is false because the care planning for a resident should be shared by the resident, the resident's family, the physician, and the nursing home staff.

Initially, a resident receives care under a baseline care plan that includes physician orders and other vital instructions. A nursing home must complete a full assessment of a resident's condition within 14 days after admission, and at least once every 12 months thereafter. More limited assessments must be done at least quarterly. Assessments are done with a standardized assessment instrument called the Minimum Data Set ("MDS").

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

A resident and/or resident's representative has a right to participate in a care plan conference. A care plan must include measurable objectives and timetables.

TIP: Too many care plans are perfunctory. Residents and family members should take care plans seriously, so that care really can be individualized.

Falsehood #2: "Ruben can't receive Medicare reimbursement because we have determined that he needs custodial care only."

Part of this statement is true – Medicare Part A indeed does not pay for custodial care. The untrue part is the assertion that the nursing home has the sole authority to determine whether the resident's care is custodial. A resident has the right to force a nursing home to bill under Medicare Part A, even if the nursing home believes that the resident needs custodial care only.

The Medicare program pays for up to 100 days of nursing home care if the resident enters the nursing home after a hospital stay of at least three nights. For Medicare Part A coverage, the resident must need skilled nursing services or skilled rehabilitation services (see Chapter 4).

COVID-19 ALERT - During the pandemic, the three-night hospital stay requirement in order to receive Medicare coverage at a nursing home is waived.

Even if the care is covered, days 21 through 100 have a daily co-payment of $176 (in 2020). Medicare supplemental insurance policies cover this co-payment, if a resident has such a policy.

The nursing home makes the initial determination on whether or not to bill Medicare, but the resident has the right to force the nursing home to submit a "demand bill." While the demand bill is being considered by the Medicare contractor, the resident cannot be charged for any amount for which Medicare subsequently may pay.

Falsehood #3: "We can't give Ruben therapy services because he isn't making progress."

This denial may be blamed on medical judgment or Medicare rules.

If the facility makes the denial based on medical judgment, the nursing home should be informed that a facility is responsible for trying to "maintain" a resident's condition: according to a relevant federal regulation, a facility must "ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable."

If the facility blames the denial on Medicare rules, there are two rebuttal points to be made. According to a federal regulation, payment source should not affect the care provided. Also, Medicare Part A reimbursement does not require "progress." Payment is possible merely if a resident needs "skilled nursing services" or "skilled rehabilitation services." *See Medicare's "Jimmo Settlement" webpage for more information.*

TIP: Talk to the nurses or therapists. They likely will want to continue their work for the resident's benefit, and can help to explain and document why skilled services are appropriate.

Falsehood #4: "We can't give Ruben therapy services because his Medicare reimbursement has expired, and Medi-Cal doesn't pay for therapy."

Nursing homes constantly attempt to tie care to payment source. This way of thinking must be resisted.

This payment-source discrimination is most obvious when a resident transfers from Medicare eligibility to Medi-Cal eligibility. There is a gross disparity between the per diem rates for the Medicare and Medi-Cal programs; a nursing home might receive $400 daily from Medicare and $200 daily from Medi-Cal.

Appropriate therapy should be provided regardless of the form of payment for two reasons. First, as discussed above, a federal regulation requires that residents receive services necessary "to attain or maintain the highest practicable physical, mental, and psychosocial well-being."

Second, services must not vary by source of payment. As set forth in another federal regulation, a nursing home "must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State [Medicaid] plan for all residents regardless of payment source."

Falsehood #5: "Because Ruben is no longer eligible for Medicare reimbursement, he must leave his Medicare-certified bed."

A nursing home may seek Medicare certification for all or some of the facility's beds. However, such distinct-part certification does not prevent a bed from being used for a resident paying privately or through Medi-Cal. Furthermore, a resident has the right under the Reform Law to refuse a transfer within a facility if the purpose of the transfer is to move the resident to or from a Medicare-certified bed.

In short, Ruben can refuse to leave and, even though his bed may be Medicare-certified, the facility can accept private payment or Medi-Cal reimbursement for the nursing home care provided to Ruben.

Falsehood #6: "Ruben must be tied into his chair so that he doesn't wander away from the nursing home."

Under the relevant federal regulation, a resident has the right to be free from "any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms." The term "physical restraint" includes (among other things) vest restraints, hand mitts, seat belts, bed rails, and chairs that are angled to prevent the resident from getting out.

A restraint can only be used with the consent of the resident or the resident's agent. (See Chapter 9 for a discussion of agents for individuals who have lost decision-making capacity.) If use of a restraint is appropriate, the nursing home must use the least restrictive alternative, for as little time as possible. The need for restraints should be re-evaluated regularly.

Although, as listed above, the law recognizes the use of restraints to protect residents, current nursing research increasingly sees the use of restraints as increasing the likelihood of falls, and/or the severity of injury in the falls that occur.

Falsehood #7: "Ruben has to wake up at 6:00 a.m. because we don't have enough nurse aides to accommodate individual schedules."

The Nursing Home Reform Law is meant to ensure that residents are treated as individual human beings. The Reform Law states that a resident has the right "to reside and receive services with reasonable accommodation of individual needs and preferences, except where the health or safety of the individual or other residents would be endangered." Also, federal regulations specify that "a resident has a right to choose activities, schedules (including sleeping and waking times), health care, and providers of health care services consistent with his or her interests, assessments, [and] plan of care."

TIP: A resident should approach these issues with a reasonable sense of entitlement. The nursing home is receiving $4,000 to $8,000 monthly for the resident's care, and should be able to make reasonable accommodations for a resident's preferences. For example, Ruben should be free to sleep as late as he wishes.

In any case, a reasonable accommodation should be a win-win situation. Accommodations can improve the residents' quality of life, and give the nursing home's operator an attractive selling point when speaking with prospective residents.

Falsehood #8: "Ruben's children can visit only during visiting hours."

A limitation on visiting hours conflicts with the idea that a nursing home should be "home." Accordingly, family and friends have the right to visit at any time. For visits late at night, official federal guidelines suggest that visits might take place outside of the resident's room – the dining room or lobby, for example.

Falsehood #9: "We don't have to readmit Ruben from the hospital because his bed-hold period has expired."

California law provides for a seven-day bed-hold. The Medi-Cal program will pay for those seven days.

An often-overlooked federal law provides an open-ended right of return for a resident eligible for Medi-Cal or Medicare payment of nursing home expenses. Even if a bed-hold has expired, a nursing home must accept the return of such a resident from the hospital whenever the nursing home first has an available bed. Return must be allowed to the same room if that room remains available.

Unscrupulous nursing homes sometimes use a temporary hospital admission as a way of evicting a resident deemed undesirable for some reason. A resident illegally denied readmission has a right to an immediate hearing from the California Department of Health Care Services. The readmission hearing request should be made by telephone to the Department's Office of Administrative Hearings and Appeals at (916) 445-9775 or (916) 322-5603.

TIP: In a hearing, a resident should not be overly concerned with proving that the nursing home has an available bed at that time. That issue is adequately covered as long as any order from the hearing officer specifies that the nursing home must admit the resident to the next available bed. With such an order, the resident is protected whether a bed is available that day or is not available until the following week.

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Falsehood #10: "Ruben must pay any amount set by the nursing home for 'extra' charges."

Nursing homes commonly charge residents separately for a host of items, and charges can amount to several hundred dollars per month. If these charges generally are not authorized by the original admission agreement, they are improper and illegal. Since 2012, California nursing facilities have been required to use a state-developed standard admission agreement. Any extra charges must be listed in Attachment B-2 to the standard agreement.

California law requires that a nursing home in the initial admission agreement specify items which carry "extra" charges, along with the amount of those charges. Also, Medicare and Medi-Cal must be accepted as payment in full, except for any share of cost deductible (see Chapters 4 & 6).

Falsehood #11: "We are not responsible for Ruben's property unless he had requested that the property be placed in the nursing home's safe."

Under California law, a nursing home is responsible for lost or stolen property if the nursing home fails to make "reasonable efforts" to safeguard that property. An admission agreement cannot reduce a nursing home's responsibility for a resident's property.

Falsehood #12: "Ruben must leave the nursing home because he is a difficult resident."

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

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

Thus "difficulty" is not a justification for eviction. Nursing homes exist in order to care for people with physical and mental problems.

A resident threatened with eviction is entitled to an administrative hearing conducted by the California Department of Health Care Services. These hearings are conducted at the nursing home. An appeal hearing can be requested by calling (916) 445-9775 or (916) 322-5603.

Falsehood #13: "Ruben must leave the nursing home because he is refusing medical treatment."

A nursing home resident, like any other individual, has a constitutional and common-law right to refuse medical treatment. Accordingly, an involuntary transfer or discharge cannot be based on a resident's refusal of treatment. Refusal of treatment is not one of the six specified justifications for eviction.

Federal guidelines state that refusal of treatment does "not constitute grounds for discharge, unless the facility is unable to meet the needs of the resident or protect the health and safety of others."

Residential Care Facilities for the Elderly (Assisted Living)

Residential Care Facilities for the Elderly ("RCFEs") are governed by California law only. This law is to a certain extent a muddle, because RCFEs are defined as non-medical facilities, although recent regulatory changes authorize RCFEs to admit and retain many residents with significant medical needs.

RCFE Falsehoods

Falsehood #14: "We won't help Ruben get dressed, because our RCFE is for independent persons only."

RCFE residents by definition need care and supervision. A state regulation specifies that an RCFE must meet its residents' needs: "Based on the individual's preadmission appraisal, and subsequent changes to that appraisal, the facility shall provide assistance and care for the resident in those activities of daily living which the resident is unable to do for himself/herself."

Facility assistance must include necessary assistance in at least the following:

- Bathing;
- Dressing;
- Grooming;
- Eating;
- Toileting;
- Continence;
- Walking;
- Transferring in and out of a bed or chair;
- Seeing;
- Hearing; and
- Speaking.

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Falsehood #15: "We have no programming because Ruben should be able to entertain himself."

Activities must be extensive, and should include education, physical activities, and socialization.

An RCFE must assure that residents maintain contact with the community. For example, residents should be able to attend church services, concerts and senior citizens events.

If a facility has a capacity of between 16 and 49 residents, one staff member must have primary responsibility for activities. If a facility has a capacity of 50 residents or more, one staff member must have full-time responsibility for activities.

Falsehood #16: "Even though Ruben now is eligible for SSI (Supplemental Security Income), he must pay the higher private rate, because he was not admitted to the RCFE as an SSI resident."

Actually, there is no such thing as an "SSI resident." All residents should get the same treatment regardless of their source of payment.

Section 87464 of Title 22 of the California Code of Regulations states that "[i]f the resident is an SSI recipient, then the basic services shall be provided and/or made available at the [SSI] basic rate at no additional charge to the resident." This regulation applies whether or not a resident was SSI-eligible when he or she was admitted.

Under 2020 SSI payment levels, an RCFE resident receives $1,206.37 monthly, and must pay an SSI basic rate of $1,069.37 monthly. This leaves the resident with a monthly personal needs allowance of $137.

If an SSI-eligible resident also has a source of income other than SSI, he will receive a total (SSI plus the other income) of $1,226.37 each month. Because this total amount is $20 more than the SSI-only amount, the resident will end up with $20 extra in his personal needs allowance. If, however, the RCFE's admission agreement stated that the facility will receive this extra $20, then the RCFE will receive a rate of $1,089.37, and the resident will receive the regular personal needs allowance of $137.

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Falsehood #17: "Ruben must leave the RCFE because he doesn't get along with the administrator."

An RCFE resident can only be evicted for one of five reasons:

1. The resident fails to pay for basic services within 10 days of the due date.

2. The resident fails to comply with state or local law after receiving written notice of the alleged violation.

3. The resident fails to comply with general facility policies set forth in the admission agreement. These facility policies explicitly "must be for the purpose of making it possible for residents to live together."

4. A formal reappraisal has found that the resident's needs have changed, and an RCFE cannot meet those changed needs.

5. The RCFE is giving up its license.

A facility must give a 30-day notice of any proposed eviction.

This notice must include information (date, place, witnesses, etc.), of any incident that allegedly justifies eviction. The notice must also include the following language, verbatim:

In order to evict a resident who remains in the facility after the effective date of the eviction, the residential care facility for the elderly must file an unlawful detainer action in superior court and receive a written judgment signed by a judge. If the facility pursues the unlawful detainer action, you must be served with a summons and complaint. You have the right to contest the eviction in writing and through a hearing.

TIP: If a resident feels that an RCFE does not have justification for an eviction, the resident should stay put, and force the facility to follow the steps for a formal eviction. An RCFE often will let the matter drop at this point because in fact the facility does not have grounds for eviction, and because the facility is likely unfamiliar with the court processes for eviction.

Selected 2020 Changes in Response to COVID-19

Nursing Homes

Visits - As of June 2020, visits are not allowed in nursing facilities, with the exception of "compassionate care situations." These include but are not limited to visits at the end of a resident's life.

Too frequently, nursing homes are being very restrictive in their understanding of "compassionate care" — limiting it exclusively to end of life and furthermore, viewing "end of life" as the absolute final hours or days of a resident's life. Families and friends should push back against this overly restrictive reading, and explain all the circumstances that might make a visit compassionate for a particular resident. Visits first were limited in early March 2020 — after months of isolation, it is entirely understandable why a resident now would desperately need an in-person visit from a family member or friend.

In any case, even in the absence of an in-person visit, the resident should have options to meet over phone or video chat with a family member or friend. Under a federal program, the facility can obtain a monetary allocation to pay for electronic tablets or other devices to facilitate contact between residents and others. In any case, of course, since most persons carry cell phones, lack of technology should never prevent a facility from finding a device for a resident to use.

Eviction - As discussed above, federal law allows eviction only under six specified circumstances. But this law has been waived by the federal government when a COVID-positive resident is transferred to a facility dedicated to care of COVID-positive residents, or when a COVID-negative resident is transferred to a facility dedicated to care of COVID-negative residents. Under the federal regulatory waiver, the resident in those circumstances is not entitled to advance notice or an appeal hearing.

Because of the regulatory waiver, residents and their representatives should be proactive in protecting the resident's interests. Particularly when a resident is or may likely be COVID-positive, the resident or representative should speak to the facility about options. Early involvement gives the resident or representative a much better chance to control or at least influence the situation. It is possible that the best place for the COVID-positive resident is the current facility or alternatively, another facility. The resident or representative should determine the best options and speak with the facility to advocate for that option. The long-term care ombudsman program representative may be a helpful ally in these discussions even though they are unable to conduct any in-person visits at the facility during this time.

Residential Care Facilities for the Elderly

Visits - State guidelines do not allow in-person visits during the initial months of the COVID-19 outbreak. The guidance does not mention any type of exception for family members or friends. As a result, residents and their family members and friends should look for the time being to meet through telephone calls or video chats. Staff should assist residents as necessary, based on the staff's basic obligation to help residents with their needs.

The no-visits rule does not apply to "outside" care providers funded by Medi-Cal, or to the long-term care ombudsman program.