

JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

Ten Common Nursing Home Problems, and How to Resolve Them

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Justice in Aging is a national organization that uses the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources.

Since 1972 we've focused our efforts primarily on populations that have traditionally lacked legal protection such as women, people of color, LGBT individuals, and people with limited English proficiency.

Diversity, Equity, and Inclusion

To achieve Justice in Aging, we must:

- Acknowledge systemic racism and discrimination
- Address the enduring negative effects of racism and differential treatment
- Promote access and equity in economic security, health care, and the courts for our nation's low-income older adults
- Recruit, support, and retain a diverse staff and board, including race, ethnicity, gender, gender identity and presentation, sexual orientation, disability, age, economic class

Why Are These Problems So Common?

And what does this say about advocacy strategies?

Nursing Facility Progress Report

- Has nursing facility quality improved or declined in recent years?
 - Significant improvement.
 - Small improvement.
 - No change.
 - Small decline.
 - Significant decline.

Half-Empty, or Half-Full?



What Can Be Done to Improve Nursing Facility Care?

- Competition from assisted living, in-home care, day centers, etc.
- Litigation.
- Demands from residents, families, others.
- Ombudsman program advocacy.
- Enforcement by licensing and certification agencies.

Facilities' Illegal Practices Must Be Called Out

- Some illegal practices have become standard operating procedure.
- Pushback needed from consumers, ombudsman programs, surveyors, etc.

Be Specific

- Residents, families and others need clear guidance.
- Identify the problem, rather than just explain the law.



Federal Law

Nursing Home Reform Law

- Enacted 1987; effective since October 1990.
- Protects all residents, regardless of payment source.

Core Principles

- Provide services that resident needs “to attain or maintain the highest practicable physical, mental, and psychosocial well-being.”
- No discrimination against Medicaid-eligible residents in providing services and in transfer/discharge.

#1--Care Planning: Falsehood and Truth

- “The nursing staff will determine the care that you receive.”
- Resident and family can participate in developing a care plan.

Care Planning

- Facility must develop and implement comprehensive person-centered care plan for each resident.”
 - 42 C.F.R. § 483.21(b)(1).

Is Care Really “Person-Centered”?

- “Person-centered care means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives.”
 - 42 C.F.R. § 483.5.

Addressing Resident Preferences

- Resident has the “right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.”
 - 42 C.F.R. § 483.10(e)(3).

Comprehensive Care Plan

- Within 7 days of assessment.
- Interdisciplinary team includes, “[t]o the extent practicable, the participation of the resident and the resident's representative(s).”
 - Written explanation needed if resident and resident don't participate.
 - 42 C.F.R. § 483.21(b).

Interdisciplinary Team

- **Must also include:**
 - Attending MD.
 - RN with responsibility for resident.
 - CNA with responsibility for resident.
 - Member of food and nutrition staff.
 - Other appropriate staff, based on resident's need or as requested by resident.

The Holy Grail of Person-Centered Care

- Regulatory language is good but compliance is poor.
- Affirmative advocacy is essential - residents may not take initiative.
- Possible strategies:
 - Publicity/Education.
 - Shaming.
 - Care planning assistance.

Residents Should Have Higher Expectations

- Resident should brainstorm a list.
 - Don't just wait for the facility to set out a few options.

#2 -- Shortchanging Medicaid-Eligible Residents: Falsehood and Truth

- “Medicaid does not pay for individual attention during meals.”
- Medicaid-eligible residents must receive equivalent care.

No Discrimination Based on Payment Source

- Facility must have “identical policies and practices regarding transfer, discharge, and the provision or services ... regardless of payment source.”
 - 42 C.F.R. §483.10(a)(2).

Remember, Medicaid Certification Is Voluntary

- In order to receive Medicaid \$, facility promises to follow federal law.
- Unfair for facility to accept money, and then shortchange resident.



#3 - Oral Health: Falsehood and Truth

- “We’re nurses, not dentists, so your teeth are not our problem.”
- The facility must provide or arrange for necessary oral health care.

Assess for Oral Health

- Assess for dental & nutritional status.
- Use Minimum Data Set (MDS)
 - Section K - ability to swallow and nutritional status.
 - Section L - oral health problems including cavities, bleeding gums, poorly fitting dentures, etc.

Facility Responsible for Resident's Oral Health

- “Must provide or obtain from an outside resource ... routine and emergency dental services to meet the needs of each resident.”
 - 42 CFR § 483.55(a)(1).

Access to Dentist

- “A dentist must be available for each resident. The dentist can be directly employed by the facility or the facility can have a written contractual agreement with a dentist.”
 - Surveyor’s Guidelines to 42 C.F.R. § 483.55(a) & (b).

Who Pays?

- Medicaid-eligible residents receive dental services to extent covered by state's Medicaid program.
 - Also, facility must notify resident of right to use monthly deductible for dental care.
- Facility can assess charges for residents paying privately or through Medicare.
 - Surveyor's Guidelines to 42 C.F.R. § 483.55(a) & (b).

Assisting Resident to Find Dental Resources

- Facility assists in finding alternative sources of dental care if resident cannot pay, e.g., dental schools.
- Facility assists in arranging for transportation.
 - Surveyor's Guidelines to 42 C.F.R. § 483.55(a) & (b).

#4 -- Right to Accept Visitors: Falsehood and Truth

- “Visiting hours are from noon to 8:00.”
- Residents can accept visitors at any time.

Right to Accept Visitors

- Resident has right to “immediate access” to visits by relatives or non-family visitors.
- Non-family visitation is “subject to reasonable clinical and safety restrictions.”
42 C.F.R. § 483.10(f)(4).
 - Does this strengthen visitation rights for family, by suggesting that family visits are not subject to restriction?

What Are “Clinical and Safety Restrictions?”

- Non-exclusive list in Surveyor’s Guideline to section 483.10(f)(4):
 - Infection-related restrictions.
 - Denying access if person
 - Is suspected of abusing resident, until investigation is completed or if allegation is confirmed.
 - Is found to have stolen or have committed another criminal act.
 - Is drunk or disruptive.

#5 -- Medicare Coverage: Falsehood and Truth

- “Medicare won’t pay because you’ve plateaued in your therapy.”
- Improvement is not required; the deciding factor is whether therapy is appropriate.

Therapy Required When Appropriate

- Facility must provide “specialized rehabilitative services” to any resident who needs them.
 - Even if care is reimbursed through Medicaid.
 - Even if resident does not show improvement.

Medicare Coverage Does Not Require “Improvement”

- E.g., Doesn’t matter if resident has “plateaued.”
- *Jimmo* litigation emphasizes regulatory right.
 - “The restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities.”
 - 42 C.F.R. § 409.32.

Appeal Procedures

- In fee-for-service Medicare, require facility to submit demand bill.
- In Medicare Advantage, right to appeal to local Quality Improvement Organization (QIO).
- Further appeals (reconsideration, ALJ, etc.) are possible, but with financial risk to resident.

Seeking Additional Days of Medicare Coverage

- Seek support from therapist and MD.
- Cite *Jimmo* info from websites of
 - CMS &
 - Center for Medicare Advocacy.

The Most Important Rule in
Avoiding Eviction Is ...

Don't Move Out!

#6 -- End of Medicare Reimbursement: Falsehood and Truth

- “You must leave when Medicare payment ends; we don’t provide custodial care.”
- Facility must give notice and wait for hearing.

Notice

- Written notice generally at least 30 days prior to date of proposed transfer/discharge.
 - Notice at “practicable” time under certain conditions, including when resident has lived in facility < 30 days.

Contents of Notice

- Reason.
- Effective Date.
- Location of new residence.
- Appeal rights.
- Contact info for ombudsman or other relevant advocacy organization.

Notice Whenever Facility Initiates Eviction

- Resident-initiated when resident (or rep) “has given written or verbal notice of their intent to leave the facility.”
- **But not:**
 - Resident’s expression of general desire or goal to return to home or the community, or
 - Elopement of a cognitively-impaired resident.
 - Surveyor’s Guideline to 42 C.F.R. § 483.15(c).

#7 -- Involuntary Transfer/Discharge: Falsehood and Truth

- “You must leave the nursing facility because you are a difficult resident.”
- Eviction is allowed only for six limited reasons.

Six Justifications for Involuntary Transfer/Discharge

1. Resident needs higher level of care.
2. Resident doesn't need nursing facility care.
3. Resident endangers others' safety.
4. Resident endangers others' health.
5. Nonpayment.
6. Facility is going out of business.
 - 42 C.F.R. § 483.15(c).

Facility Should Cope with “Difficulty”

- Facility should be well prepared to deal with dementia and other conditions.
- Any “difficulty” should lead to renewed care planning, rather than to transfer/discharge.

Facility Must Document Inability to Meet Resident's Needs

- Specific needs that allegedly can't be met.
- Facility's attempts to meet those needs.
- Ability of receiving facility to meet those needs.

#8 -- Returning from Hospital: Falsehood and Truth

- “You can’t return because your bed hold has expired.”
- Medicaid-eligible resident can return to next available bed.

Returning to Facility After Hospitalization

- Facility must give notice of bed-hold policy.
- Facility also must allow return to next available room.
 - If resident eligible for Medicaid or Medicare coverage of NF care.
 - Must be previous room, if available.
 - 42 C.F.R. § 483.15(e).

Resident Allowed to Return Pending Hearing

- If facility “determines that a resident who was transferred with an expectation of returning to the facility cannot return to the facility,” the facility must comply with transfer/discharge requirements.
 - 42 C.F.R. § 483.15(e)(1)(B)(ii).
- Surveyor’s Guidelines: “resident must be permitted to return and resume residence in the facility while an appeal is pending.”

Preventing “Dumping” at Hospital

- Quick action from survey agency.
- Lawsuit seeking injunctive relief.
- Pressure from hospital.

#9 -- Admission Agreements: Falsehood and Truth

- “Your daughter has to sign the admission agreement as ‘responsible party.’”
- A nursing facility must not obtain a third-party guarantee of payment.

No Financial Guarantees Allowed

- Third-party guarantees cannot be required or requested.
 - This does not prevent a third party (adult child, etc.) from signing an agreement as agent, obligating the resident to pay nursing facility charges.
 - 42 C.F.R. § 483.15(a).

Some Facilities Still Seek to Collect Against Family Members

- Some facilities attempt to file suit against family member/agent for unpaid bill.
 - These suits generally should fail, unless family member was looting resident's finances for family member's own benefit.

How Resident Avoids Signing “Bad” Admission Agreement

- Delete or revise improper provisions.
- Explain how provisions violate law.
- No risk of being refused admission if resident already has moved in.

#10 -- Arbitration Agreements: Falsehood and Truth

- “Arbitration is more efficient than litigation.”
- There is no good reason for a resident to commit blindly to arbitration for all future disputes.

Federal Reg Bars Pre-Dispute Arbitration Agreement, But ...

- Mississippi federal court ruling enjoins enforcement of regulation.
- CMS is preparing to replace regulation with presumably pro-arbitration regulation.

Residents Should Refuse to Sign Arbitration Agreements

- Why is arbitration generally bad option for residents?
 - Arbitrator may tend to favor facility, who often is repeat customer.
 - Arbitrator is generally less empathetic than jury.
 - Arbitration agreements may have provisions that disadvantage residents.

Strongest Argument Against “Pre-Dispute” Arbitration Agreements

- Arbitration agreements are best for when dispute already has occurred, and both parties understand what is at stake.

How Resident Avoids Signing Arbitration Agreement

- Often agreement itself says that arbitration is voluntary.
- No risk of being refused admission if resident already has moved in.

Additional Resources

- **Websites of:**
 - National Consumer Voice for Quality Long-Term Care
 - Center for Medicare Advocacy
 - Long Term Care Community Coalition (especially info on deficiencies and staffing levels)
 - California Advocates for Nursing Home Reform
- **Long-Term Care Advocacy (Carlson)**
(legal treatise)

Questions?

- Text 51555 with the message “4justice” to receive Justice in Aging legal alerts.
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