Common Nursing Home Problems, and How to Resolve Them

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Justice in Aging is a national non-profit organization that fights senior poverty through law. We secure health and economic security for older adults of limited income and resources by preserving their access to the courts, advocating for laws that protect their rights, and training advocates around the country to serve the growing number of older Americans living in poverty.

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By Eric Carlson

WITH SUPPORT FROM THE COMMONWEALTH FUND
Nursing Home Reform Law

- Applies to every facility certified for Medicare and/or Medicaid.
  - Applies regardless of resident’s payment source.

- See 42 U.S.C. §§ 1395i-3 (Medicare certification), 1396r (Medicaid certification); 42 C.F.R. § 483.
Two Important Rules

• Facility must provide services that resident needs “to attain or maintain the highest practicable physical, mental, and psychosocial well-being.”
  – 42 C.F.R. § 483.25.

• No discrimination based on payment source.
  – 42 C.F.R. § 483.12(c)(1).
Problem # 1: “John Jr. must sign as ‘Responsible Party.’”

• “Responsible Party” is financially liable.
  – But Reform Law prohibits facilities from requiring financial guarantees.
    • 42C.F.R. § 483.12(d).

  – Facilities claim that person “volunteers” to become “Responsible Party.”
‘Responsible Party’ Provisions Are Illegal and Unenforceable

• Why illegal?
  1. Facility actually is requiring guarantee.
  2. Family members are deceived.
  3. No benefit provided.
Possibility of Liability if Family Member/Friend Has Misused Funds

• Recent agreements have “responsible party” agree to pay fees from resident’s funds (if RP has access), and apply for Medicaid for resident.

• If nonpayment, facility argues that “responsible party” has breached duty.

• Courts vary as to whether the “responsible party” can be held liable.
Standard Nursing Home Admission Agreement

• Should resolve problem going forward.
Problem # 2: “Sign this arbitration agreement; it’s no big deal.””

• There is no reason to agree to arbitration at the time of admission.

• Look closely at the agreement – it may state that arbitration is voluntary.
Problem #3: “Nursing staff will determine the care that John receives.”

• Assessments done within 14 days.

• Care plan completed within 7 days of assessment.

• Resident and resident’s representative participate in preparation of care plan.
  – 42 C.F.R. § 483.20.
Some Care Planning Is Deficient!!!

• Problems include:
  – Facilities just going through the motions.
  – Care planning meetings scheduled at inconvenient times, for short periods of time.
  – Meeting conducted with assumption that resident and/or family will just rubber-stamp facility’s intentions.
Anxiety Problems

☐ Anxiety as manifested by
☐ Anxiety as manifested by

[Signature]
Anxiety Goals

Resident will verbalize and/or demonstrate decreased anxiety level.

6 months

90 Days
Anxiety Interventions

Encourage to verbalize feelings; give realistic, positive feedback. Attempt to identify sources of anxiety and help to resolve where appropriate. Diversional activities to redirect attention away from anxiety, e.g. ___

____________________

____________________
Keys to Better Care Planning

• Resident has reasonable sense of entitlement to individualized care.

• Resident determines what he or she needs and wants.

• Resident and/or family member speak up for themselves during care planning meetings.
Problem #4: “Medicaid does not pay for the service that you want.”

- A facility “must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services required under the State [Medicaid] plan for all individuals regardless of source of payment.”
  - 42 C.F.R. § 483.12(c) (emphasis added).
Medicaid-Eligible Residents Are Not Second-Class Citizens

• Reform Law requires high quality care for all residents.
• A facility must not discriminate on the basis of payment source.
• Don’t capitulate to facility tales of financial woe; it is hypocritical for facility to accept Medicaid money and then plead poverty as an excuse.
Problem #5: “Because of John’s limited needs, he can’t get Medicare payment.”

- Medicare pays for up to 100 days, if resident...
  - Is hospitalized for at least three nights; and
  - Needs skilled nursing services or skilled rehabilitation services.

- Days 21 through 100 have daily co-payment of $161.
Nursing facility makes initial determination on whether or not to submit bill.

Resident has right to force facility to submit a “demand bill.”

- During consideration of bill, resident cannot be charged for any amount for which Medicare subsequently may pay.
Resident receives Denial of Medical Coverage.

Resident can ask for fast appeal decision (within 72 hours) with showing that health could be harmed if forced to wait 30 days for standard appeal decision.

- Resident potentially liable for private payment while waiting for appeal decision, if appeal decision ultimately is unfavorable.
Problem #6: We must discontinue therapy because John isn’t making any progress.”

• Several reasons for continuing therapy:
  – Medical judgment:
    • Facility is responsible for trying to “maintain” resident's condition.
  – Medicare rules:
    • Payment source should not affect the care provided.
    • Medicare payment does not necessarily require “progress.”
      – 42 C.F.R. § 409.32(c); Recent Jimmo v. Sibelius settlement.
Appealing Terminations in Medicare Managed Care

- Resident receives Notice of Medicare Non-Coverage at least two days before proposed termination of coverage.
  - For fast track appeal, resident must appeal to Quality Improvement Organization (QIO) by noon on following day (day 1).
  - Resident should receive appeal decision by day 2.
  - If resident loses and does not leave, she is financially liable beginning on day 3.
Problem #7: “No therapy; Medicare has expired and Medicaid doesn’t cover it.”

- Reasons for continuing therapy:
  - Services required by Reform Law.
  - Payment source should not affect care provided.
  - Therapy must be provided under Medicaid daily rate.
Problem #8: “John isn’t eligible for Medicare, so he must leave his Medicare bed.”

• Medicare certification does not prevent bed from being used for private payment or Medicaid reimbursement (assuming bed also is certified for Medicaid).

• Under Reform Law, resident can refuse transfer within facility if purpose of transfer is to move resident to or from Medicare-certified bed.
Problem #9: “*If we don’t tie John into his chair, he may fall or wander away.*”

- Resident has right to be free from “any physical or chemical restraint imposed for purposes of discipline or convenience and not required to treat the resident’s medical symptoms.”
  

- Use of restraints requires physician order and informed consent by resident or resident’s representative.
Do Physical Restraints Keep Residents Safer?

• Role Reversal – sometimes families ask for physical restraints and facilities resist.

• Studies show that restraints are physically and emotionally harmful.

• Serious injuries can occur, e.g., asphyxiation after being tangled in restraints.
“Falls do not ... warrant[] the use of a physical restraint. Although restraints have been traditionally used as a falls prevention approach, they have major, serious drawbacks and can contribute to serious injuries. There is no evidence that the use of physical restraints, including but not limited to side rails, will prevent or reduce falls. Additionally, falls that occur while a person is physically restrained often result in more severe injuries (e.g., strangulation, entrapment)."
Problem #10: “We don’t have enough staff. John must wake up at six a.m.”

• A resident has right “to reside and receive services with reasonable accommodation of individual needs and preferences.”
  – 42 U.S.C. §§ 1395i-3(c)(1), 1396r(c)(1).

• “[A] resident has the right to [c]hoose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care.”
  – 42 C.F.R. § 483.15.
Increased Focus on Person-Centered Care

• Throughout long-term services and supports, the better care providers are basing care on resident preferences.

• “Culture change” movement calls for
  – More decisions by residents.
  – More autonomy and responsibility for direct-care staff members.
Problem #11: “We don’t have enough staff; you should hire a private duty aide.”

• Facility must provide the care necessary for resident to reach the highest practical level of functioning.
  – 42 C.F.R. § 483.25.

• Expense of care is not an excuse; after facilities, a facility does not give refunds for residents with light care needs.
Problem #12: “We must insert a feeding tube; John is eating too slowly.”

- Facility must assist resident in maintaining resident’s ability to eat.

- Tube feeding should be done only if absolutely necessary.
  - 42 C.F.R. § 483.25(g).
Family and friends have the right to visit at any time.

– “Immediate family or other relatives are not subject to visiting hour limitations or other restrictions not imposed by the resident. Likewise, facilities must provide 24-hour access to other non-relative visitors who are visiting with the consent of the resident.”

• CMS, Surveyor’s Guideline to 42 C.F.R. § 483.10(j)

Problem #13: “John’s children can visit only during visiting hours.”
Problem #14: “We don’t have to readmit John from hospital; his bed-hold is over.”

- A resident eligible for Medicaid has the right to be readmitted to the next available Medicaid-certified bed, regardless of the length of the hospital stay.
  - 42 C.F.R. § 483.12(b).
  - Advocacy tip – don’t worry about proving that a bed is available immediately.
Problem #15: “You must pay any amount set by the facility for extra charges.”

- Amount of charges limited by admission agreement, based on principles of contract law.
  - 42 C.F.R. § 483.10(b)(6) (requirement that charges be listed).
- Medicare and Medicaid must be accepted as payment in full.
Problem #16: “John must leave because he is a difficult resident.”

- Only six legitimate reasons for eviction:
  1. Resident failed to pay.
  2. Resident no longer needs nursing facility care.
  3. Facility is going out of business.
  4. Resident’s needs cannot be met in a nursing facility.
  5. Resident’s presence in facility endangers others’ safety.
  6. Resident’s presence in facility endangers others’ health.
Eviction Based on Resident’s Condition Should Be Very Rare

- Nursing facilities exist in order to take care of persons with significant care needs, many of whom have dementia.
- It is pointless and often counterproductive to transfer a “difficult” resident from one facility to another.
Resident Can Appeal

- Facility issues written transfer/discharge notice, generally 30 days in advance.
- Resident can obtain review from hearing officer.
  - In hearing, important to focus on what facility should do, rather than blame resident for “misbehaving.”
Problem #17: “You’re evicted on a past-due private-pay charge, even though you’re now Medicaid-eligible.”

- For evictions for nonpayment, “in the case of a resident who becomes eligible for assistance under [Medicaid] after admission ..., only charges which may be imposed under [Medicaid] shall be considered to be allowable.”
  
  – 42 U.S.C. § 1396r(c)(2)(A); see also 42 C.F.R. § 483.12(a)(2)(v).
Helpful Restatement by Kansas Court of Appeals

• “In other words, when an individual originally admitted as a ‘private pay’ resident later qualifies for Medicaid assistance, the individual cannot be discharged for failing to pay the debt he or she has incurred as a ‘private pay’ resident.”

Also, “Old” Medical Bills Can Be Paid through Current Patient-Pay Amount

• Money still due even if facility cannot evict.
• Payments towards “old” bills can be made with current patient-pay amount.
  – Example: Resident owes $10,000 for past-due bill, and has monthly $1,000 patient-pay obligation to nursing facility. If the $1,000/month payment is directed to the $10,000 bill, that bill will be paid off in ten months. Medicaid bill pay the current month’s bill in full, once the resident satisfies the monthly $1,000 obligation.
Questions?

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