

Touring the Nursing Home: Issues for the Elder Law Attorney

Nashville, TN - December 5, 2003

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§ 1.0 Background and Introduction.

Elders are forced to mistrust their own capabilities. Time takes its toll on even those who have been healthy and able to maintain sturdy muscles, and the body inevitably weakens. Hope may easily give way to despair in the face of continual and increasing disintegration, and in light of both chronic and sudden indignities. Even the simple activities of daily living may present difficulty and conflict. No wonder elders become tired and often depressed. Yet elders readily accept that the sun goes down at night and rejoice to see it rise brightly every morning. While there is light, there is hope, and who knows what bright light and revelation any morning may bring. J. Erikson, The Life Cycle Completed: Extended Version with New Chapters on the Ninth Stage of Development 107 (Norton 1997).

Are we, as a society, entitled to quality health care and, if so, what is the level of care that the aged members of our society are entitled to receive?

Elder Law Attorneys deal in hope. We routinely assist frail clients. Often, frail clients are receiving medical assistance and are facing a nursing home admission, or will be soon.² Our clients bring us problems, hoping we will provide solutions. Our role is to make a positive difference in their lives. With that in mind, if we intend to deliver hope, then we must know how to guide our Elder clients, and their families, through the long term care labyrinth to secure the highest quality of care at the minimum cost. This requires knowledge and a willingness to become involved in the client's life.

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² "Nursing home" is a defined term in Tennessee. See T.C.A. § 68-11-201(25).

Our role may require a new way of looking at the health care community. As lawyers, we were trained to participate in an adversarial process. Given our training and bent, and given the current legal climate, the health care community often views us as antagonists. That is not our role. Instead, we should be concerned with something more than the rough and tumble of litigation.³ We should take an Elder-centered approach to long-term care and should view the penumbra of nursing home regulation as *a vision* of what nursing home care *can be* when it is provided correctly. This may require collaboration. Quality care must be the goal because, when it is provided, it fills our clients and their families with the hope brought by a new morning sun. When care is provided improperly, we all lose.

We start with recognition that Elders often require substantial medical care. As Erikson points out, time catches up with all of us. Statistics show that serious health or disabling conditions usually lead to residence in a nursing home because those conditions cannot be managed at home.⁴ There are many facilities which can provide necessary care. As shown in the *National Nursing Home Survey: 1999 Summary*, published in June, 2002 (CDC, Vital and Health Statistics, Series 12, Number 152), as of 1999, there were 18,000 nursing homes nation-wide.⁵ Those facilities provided care for 1.6 million nursing home residents; 90% of those residents were aged 65 or older. Once admitted, the average length of stay for residents was 892 days. Approximately seventy-five percent required assistance with three or more activities of daily living (ADLs).⁶ These statistics demonstrate both need and capacity to meet needs.

To effectively assist our clients, we must position ourselves and our clients to work with the health care community and within the system. We do this by anticipating problems, avoiding problems that are preventable and by identifying and resolving neglect and abuse situations.⁷

The nursing home resident needs a health care advocate. So does the nursing home industry which, seems to be mired in a sense of frustration and despair. Elder Law Attorneys fill this role and, as “Health Care Advocates” for the Elderly, they will become more vital as America’s population ages during the next thirty (30) years. As of 1985, the percentage of persons 65 years and older residing in nursing homes was 5%. A joint study conducted by the University of

³ Lawyers, particularly those providing counsel, should adopt a principlism approach to Elder Law similar to that advocated in T. Beauchamp & J. Childress, *Principles of Biomedical Ethics, Fifth Edition* (Oxford University Press 2001). The four elements of principlism are autonomy, nonmaleficence, beneficence, and justice. If litigation is the goal rather than a tool used when goals are not met, then we ignore nonmaleficence and beneficence.

⁴ See Administration on Aging, *Statistics: Aging into the 21st Century*, available at http://www.aoa.gov/Statistics/futurre_groth/against21/health.asp.

⁵ In 2001, there were 352 nursing homes licensed in Tennessee, with more than 39,500 patient beds. See <http://www.thca.org/nursinghome.htm>.

⁶ ADLs include the resident’s ability to bathe, dress and groom, transfer and ambulate, toilet, eat and use speech, language or other communication systems. 42 C.F.R. § 483.25(a).

⁷ As Elder Advocates, we hope that every client who is admitted to a nursing home will live comfortably and will die of natural causes. However, that does not always happen where the nursing home resident lacks the ability to speak for herself regarding concerns. In the context of this article, we presume the health care community intends to provide quality care. Thus, by understanding and pointing out neglect and abuse, it should be resolved.

Illinois and the University of Chicago found that if residency ratios remain constant, the number of nursing home residents will double or triple by 2030.⁸

AGES 65 AND UP	July 1, 1995	July 1, 2000	July 1, 2005	July 1, 2015	July 1, 2025
TOTAL 65+	33,537	34,707	36,171	45,571	61,954
Tennessee.....	658	707	760	994	1,355

Projections of the 65+ Population of States: 1995 to 2025
 (Numbers in thousands. Resident population. Series A projections. For more details, see Population Paper Listings #47, "Population Projections for States, by Age, Sex, Race, and Hispanic Origin: 1995 to 2025.")
 Source: <http://www.census.gov/population/projections/state/stpage.txt>

§ 1.1 Case Study: The Problem.

Jim is 55 years old. His Mom is 78. Mom has been living with Jim and his wife since 1997, when Mom had a mild stroke. Mom fell at home 10 days ago and broke her hip. She was admitted to the local hospital and is still there. Yesterday, Mom’s doctors told Jim that she will soon be discharged from the hospital but that she needs more care than Jim can provide at home. The doctor wants to admit her to a nursing home for rehabilitation. Jim visited the Jones Nursing Home this morning and discovered they have an available bed. Now Jim is your office wondering what to do.⁹

Practice Note: We generally provide our clients with a copy of S. Burger et al., *Nursing Homes: Getting Good Care There, 2nd Ed.* (National Citizen’s Coalition for Nursing Home Reform 2001) and provide advice concerning expectations and the care nursing homes should provide. Other law firms, such as The Elder Law Practice of Timothy L. Takacs, have developed educational programs that help family members understand how nursing homes work and what to expect. Regardless of how these issues are approached, it is clear that families facing a nursing home admission will look to Elder Law Attorneys for counsel and we should be prepared to provide it.

§ 2.0 Advanced Directives:

Assuming Jim’s Mom retained the Elder Law Attorney prior to the nursing home admission, advanced directives should be in place. Advanced directives may include a Durable Power of Attorney for Health Care, a Durable General Power of Attorney, A Living Will and a Do Not Resuscitate Order, and a HIPAA Release. *See* 42 U.S.C. § 1395cc(f)(3); Tenn. Comp. R. & Regs. 1200-8-6-.01(2).

Tenn. Comp. R. & Regs. 1200-8-6-.01 defines the following terms:

⁸ See AOA, *supra*, footnote 2.

⁹ The focus of this articles is nursing home advocacy rather than Medicaid Planning. For information regarding nursing home Medicaid in Tennessee, see T. Takacs, *Elder Law Practice in Tennessee* (Lexis 1998, 2003).

(15) Health care decision. A decision made by an individual or the individual's health care decision-maker, regarding the individual's health care including but not limited to: (a) the selection and discharge of health-care providers and institutions; (b) approval or disapproval of diagnostic tests, surgical procedures, programs of administration of medication, and orders not to resuscitate; (c) directions to provide, withhold or withdraw artificial nutrition and hydration and all other forms of health care; and (d) transfer to other health care facilities.

(16) Health Care Decision-maker. In the case of an incompetent resident, or a resident who lacks decision-making capacity, the resident's health care decision-maker is one of the following: the resident's health care agent as specified in an advance directive, the resident's court-appointed legal guardian or conservator with health care decision-making authority, or the resident's surrogate as determined pursuant to Rule 1200-8-6-.13 or T.C.A. § 33-3-220.

Advocacy should begin with planning *before* care is necessary. Mom is now in a situation where family members must help her communicate with the medical community. A properly drafted Durable Power of Attorney for Health Care will facilitate the communication process. *See* T.C.A. § 34-6-201 et seq. For information regarding advances directives in Tennessee; *see also* T. Takacs, *Elder Law Practice In Tennessee* (Lexis 1998, 2003), Chapter 11; C. Krohm & S. Summers, *Advance Health Care Directives: A Handbook for Professionals* (ABA 2002).

If Mom has not executed an advanced directive, then assuming Mom is still competent (Tenn. Comp. R. & Regs. 1200-8-6-.01(8)),¹⁰ the Elder Law Attorney should take immediate steps to assist Mom in executing a Health Care Power of Attorney.

In Tennessee, a Power of Attorney for Health Care (*see, generally*, T.C.A. § 34-6-201 to § 34-6-216) is not valid unless it is executed as follows:

(a) An attorney in fact under a durable power of attorney for health care may not make health care decisions unless all of the following requirements are satisfied:

- (1) The durable power of attorney for health care specifically authorizes the attorney in fact to make health care decisions;
- (2) The durable power of attorney for health care contains the date of its execution; and
- (3) The durable power of attorney for health care is executed by the following method: the durable power of attorney for health care is signed and acknowledged before a notary public by the principal and is signed by at least two (2) witnesses who witnessed the signing of the instrument by the principal, with each witness making the following declaration in substance: "I declare under penalty of perjury under the laws of Tennessee that the person who signed this document is personally known to me to be the principal; that the principal signed this durable power of attorney in my presence; that the principal appears to be of sound mind and under no duress, fraud or undue influence; that I am not the person appointed as attorney in fact by this document; that I am not a health care provider, an employee of a health care provider, the

¹⁰ "Competent" means "having decision-making capacity." "Decision-making capacity" is further defined as a condition "shown by the fact that the person is able to understand the proposed procedure, its risks and benefits, and the available alternative procedures." Tenn. Comp. R. & Regs. 1200-8-6-.01(9). *See also* T. Takacs, *Elder Law Practice in Tennessee, supra*, Chapter 2. "Lacks decision-making capacity" is defined at Tenn. Comp. R. & Regs. 1200-8-6-.01(22).

operator of a health care institution nor an employee of an operator of a health care institution; that I am not related to the principal by blood, marriage, or adoption; that, to the best of my knowledge, I do not, at the present time, have a claim against any portion of the estate of the principal upon the principal's death; and that, to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will or codicil thereto now existing, or by operation of law."

Related issues:

1. Patient Self Determination Act. The federal Patient Self Determination Act is covered in T. Takacs, *Elder Law Practice in Tennessee, supra*, § 11-1(d). Essentially, the Act requires that health care providers “maintain **written policies and procedures** with respect to all adult individuals receiving medical care by or through the provider ... **concerning** - (i) an individual's **rights under State law** (whether statutory or as recognized by the courts of the State) **to make decisions concerning such medical care**, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives (as defined in paragraph (3)), and (ii) the written policies of the provider or organization respecting the implementation of such rights” 42 U.S.C. § 1395cc(f)(1) (Emphasis added). The resident’s medical record must note whether an advanced directive is in place. 42 U.S.C. § 1395cc(f)(1)(B). Care cannot be conditioned on execution of an advanced directive. 42 U.S.C. § 1395cc(f)(1)(C).¹¹ The facility must provide the information regarding its policy at the time of admission to the nursing home. 42 U.S.C. § 1395cc(f)(2)(B).
 - a. Access to information necessary to make decisions. 42 C.F.R. § 483.10(b)¹² guarantees access to information necessary to make self determination decisions as follows:

(2) The resident or his or her legal representative has the right--

(i) Upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays); and

(ii) After receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and 2 working days advance notice to the facility.

(3) The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.

¹¹ Occasionally, nursing homes violate this statute by requiring execution of an advanced directive at the time of admission.

¹² Should litigation become necessary, this regulation also guarantees access to records that an expert should review before a malpractice action is filed.

- b. Tennessee Statute & Regs. *See also* T.C.A. § 68-11-901(10) (right to be fully informed) & (11) (right to refuse treatment); Tenn. Comp. R. & Regs. 1200-8-6-.12(m) (right to be fully informed) & (n) (right to refuse treatment).
 - c. HIPAA. It is now common to hear that health care providers will not provide protected health information to persons other than the resident and the resident's agent under a valid health care power of attorney. That, however, frustrates self determination since it is impossible to give informed consent without knowledge of the resident's condition. HIPAA, the Health Insurance Portability and Accountability Act of 1996, is not so limited and such refusals violate both the spirit and intent of the statute. HIPAA expressly allows (but does not require) health care providers to share information with family. *See* 45 C.F.R. § 164.510(b)(1)(i). Nonetheless, it may be wise to avoid the argument by providing family members who will visit Mom with a HIPAA compliant release. This will not allow family members, other than the agent under a HCPOA to make medical decisions, but it will allow them to "check up" on Mom. For information regarding HIPAA related communication issues, *see* D. McGuffey, *How to eat a HIPAA: Medical Records and the Elder Law Attorney*, NAELA e-Bulletin, October 7, 2003.
 - d. Right to Refuse Treatment. The OBRA regulations specifically authorize residents to refuse treatment. 42 C.F.R. § 493.10(b)(4).
2. Living Wills. *See* T.C.A. § 32-11-101 to 32-11-112. A living will states the resident/patient's intentions regarding the continuation or discontinuation of health care treatment after reaching a persistent vegetative state (or terminal condition). In that regard, T.C.A. § 32-11-102(a) provides: "The general assembly declares it to be the law of the state of Tennessee that every person has the fundamental and inherent right *to die naturally with as much dignity as circumstances permit and to accept, refuse, withdraw from, or otherwise control decisions relating to the rendering of the person's own medical care, specifically including palliative care and the use of extraordinary procedures and treatment.*" (Emphasis added).
- a. Elder advocates should recognize that there is a difference between a natural death with dignity and death as a result of sub-standard care.
 - b. Medically futile acts. Unless care would be futile, a Living Will or a DNR does not serve as an excuse to abandon a resident. "Medically futile acts" are "resuscitation efforts that cannot be expected either to

restore cardiac or respiratory function to the resident or to achieve the expressed goals of the informed resident. In the case of the incompetent resident, the resident's representative expresses the goals of the resident.” *See* Tenn. Comp. R. & Regs. 1200-8-6-.01(30).

- c. Right to refuse treatment. Nursing home residents retain the right to refuse treatment. *See* T.C.A. § 68-11-901(11).
3. Do Not Resuscitate Orders. *See, generally,* T.C.A. § 68-140-601 to § 68-140-604.
4. Decision Making for Incompetent Residents. Pursuant to Tenn. Comp. R. & Regs. 1200-8-6-.13, nursing homes must: “maintain and establish policies and procedures governing the designation of a health care decision-maker for making health care decisions for a resident who is incompetent or who lacks decision-making capacity, including but not limited to allowing the withholding of CPR measures from individual residents. The policies and procedures for determining when resuscitative services may be withheld must respect the resident's rights of self-determination. The nursing home must inform the resident and/or the resident's health care decision-maker of these policies and procedures upon admission or at such time as may be appropriate.” Subsection “(4)” provides: **In the case of a resident who lacks decision-making capacity and who has not appointed an individual to act on his or her behalf** pursuant to an advance directive and who does not have a court-appointed guardian or conservator with health care decision-making authority, **documentation in the medical record must identify the resident's surrogate to make health care decisions on the resident's behalf.** (a) The resident's surrogate shall be an adult who: 1. has Appendixed special care and concern for the resident, who is familiar with the resident's personal values, and who is reasonably available; and 2. consideration shall if possible be given in order of descending preference for service as a surrogate to: (i) the resident's spouse, (ii) the resident's adult child, (iii) the resident's parent, (iv) the resident's adult sibling, (v) any other adult relative of the resident, or (vi) any other adult who satisfies the requirement under part 1 above.
5. Conservatorship. A Conservatorship is a poor second choice in assisting Mom with her health care because it requires Court approval of most significant decisions. This can be both costly and time consuming. However, there may be circumstances where it is the only option. In those cases, the Elder Law Attorney should assist the client as necessary in securing authority to assist Mom. The conservatorship statute is found at T.C.A. § 34-1-101 et seq. *See also* Tenn. Comp. R. & Regs. 1200-8-6-.01(23).

6. Improper Use of A Fiduciary Position. Advanced directives can be abused. It is becoming more common to hear about the improper use of a fiduciary position. Recently, the following was announced: “Attorney General Mike Cox [Michigan] filed embezzlement charges today against the son and daughter in-law of a nursing home resident who was forced to go onto Medicaid after her personal accounts were depleted.” See <http://www.michigan.gov/ag/0,1607,7-164--69529--,00.html>. If Medicaid Planning is done, it should be done with an “elder-centered” focus; otherwise, the courts may second guess what was done. See also *In re Estate of Myers*, 2003 WL 22037527 (Tenn. Ct. App. Jan. 8, 2003) (“The transfer of the funds from the CD to the attorney-in-fact certainly benefited Brooxie Myers. It also had the effect of depriving Ms. Merle of the bulk of her financial resources. A transaction that impoverishes the purported donor cannot be considered fair [absent instructions from the principal or necessity].”). As Elder Law Attorneys, we must be vigilant in explaining advanced directives to our clients, and in placing appropriate safeguards in those documents to prevent abuse.

As Jim searches for quality nursing home care, his first task is to discover the level of care Mom will need. Candid conversations with Mom’s physicians may provide this information. If Jim has a HCPOA or a HIPAA release, he is more likely to secure the information he needs on a timely basis. Jim should then look for a facility that can meet Mom’s needs. The Elder Law Attorney can help by sharing her experience with Jim.

§ 3.0 Hospital Discharge Planning:

Often Elders, as in the example above, are transferred from a hospital to a nursing home. In those situations, resident advocacy should begin with hospital discharge planning. Consistent with 42 C.F.R. 482.43:

- (1) The hospital must provide a discharge planning evaluation to the patients identified in paragraph (a) of this section, and to other patients upon the patient's request, the request of a person acting on the patient's behalf, or the request of the physician.
- (2) A registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise the development of, the evaluation.
- (3) The discharge planning evaluation must include an evaluation of the likelihood of a patient needing post- hospital services and of the availability of the services.
- (4) The discharge planning evaluation must include an evaluation of the likelihood of a patient's capacity for self-care or of the possibility of the patient being cared for in the environment from which he or she entered the hospital.
- (5) The hospital personnel must complete the evaluation on a timely basis so that appropriate arrangements for post-hospital care are made before discharge, and to avoid unnecessary delays in discharge.
- (6) The hospital must include the discharge planning evaluation in the patient's medical record for use in establishing an appropriate discharge plan and must discuss the results of the evaluation with the patient or individual acting on his or her behalf.

In Tennessee, discharge planning is regulated pursuant to Tenn. Comp. R. & Regs. 1200-8-1-.05 as follows:

(8) The hospital must ensure continuity of care and provide an effective discharge planning process that applies to all patients. The hospital's discharge planning process, including discharge policies and procedures, must be specified in writing and must: (a) Be developed and/or supervised by a registered nurse, social worker or other appropriately qualified personnel; (b) Begin upon admission of any patient who is likely to suffer adverse health consequences; (c) Be provided when identified as a need by the patient, a person acting on the patient's behalf, or by the physician; (d) Include the likelihood of a patient's capacity for self-care or the possibility of the patient returning to his or her pre-hospitalization environment; (e) Identify the patient's continuing physical, emotional, housekeeping, transportation, social and other needs and must make arrangements to meet those needs; (f) **Be completed on a timely basis to allow for arrangement of post-hospital care and to avoid unnecessary delays in discharge;** (g) **Involve the patient, the patient's family or individual acting on the patient's behalf,** the attending physician, nursing and social work professionals and other appropriate staff, and must be documented in the patient's medical record; and (h) Be conducted on an ongoing basis throughout the continuum of hospital care. Coordination of services may involve promoting communication to facilitate family support, social work, nursing care, consultation, referral or other follow-up. [Emphasis added]

(9) A discharge plan is required on every patient, even if the discharge is to home.

(10) The hospital must arrange for the initial implementation of the patient's discharge plan and must reassess the patient's discharge plan if there are factors that may affect continuing care needs or the appropriateness of the discharge plan.

Discharge planning serves several functions. **First**, it can serve as a basis for securing Medicare funding for up to 100 days of skilled nursing care following a qualifying hospital stay.¹³ Medicare coverage opens doors, creating choice regarding nursing home placement because the Medicare rate is higher than the Medicaid rate. **Second**, discharge planning forces the hospital to focus on the Elder's needs, to develop an assessment regarding the level of care needs, and to plan proactively to meet those needs, either by maintaining or improving health. As ample literature shows, hospital employees are often better paid and, as a result, are better trained to anticipate and plan for the Elder's needs. The Elder should avail herself of that expertise. **Third**, the discharge plan is one method of communicating the Elder's continuing needs to the nursing home. The plan must be placed in the medical record and, accordingly, is available to the nursing home as it develops a continuing care plan. The hospital discharge plan should be used in assessing and care planning for the Elder following an initial nursing home admission (or following a re-admission). For more information regarding the attorney's role in the discharge planning process, see J. Sangerman & J. Levy, *The Attorney's Role in the Hospital Discharge Planning Process for the Elderly* (2001) (covering federal and New York law), available at http://www.sangerman.com/html/body_hospital_discharge_planning.html.

¹³ See discussion of eligibility requirements in J. Stein & A. Chiplin, *2003 Medicare Handbook*, Chapter 3 (Aspen Publishing). Medicare will cover 100% of the first 20 days of skilled nursing care, and all but the daily co-pay (in FY2003, \$105 per day) of days 21 through 100 *if* skilled care is required. Appropriate documentation to secure this coverage is discussed in the *2003 Medicare Handbook* at § 3.07[D].

§ 4.0 Finding and Evaluating the Nursing Home.

Finding “the right” nursing home can be an emotional ordeal for the resident’s family. Elder Law Attorneys can provide support during this process by making information available. Elder Law Attorneys can get the ball rolling by providing clients with a copy of CMS’s *Guide to Choosing a Nursing Home*. See <http://www.medicare.gov/Publications/Pubs/pdf/02174.pdf>.

§ 4.1 Finding the Right Nursing Home:

Eric Carlson counsels that hospital discharge planners are a resource that should be used in selecting the right nursing home. “Discharge planners generally are very familiar with the strengths and weaknesses of local nursing facilities. A conscientious discharge planner can steer patients away from bad nursing facilities and towards the good facilities.” See E. Carlson, *Long Term Care Advocacy* § 3.02[g] (Lexis-Nexis 2002); see also Tenn. Comp. R. & Regs. 1200-8-1-.05(12) (transfer must be to appropriate facilities). However, less conscientious discharge planners may focus on trying “to stay on good terms with all of the local nursing facilities,” so their advice should be reviewed with care. *Id.*

Multiple websites list nursing homes in local areas. For example, Appendix A is a list of nursing homes in Davidson County, Tennessee. The list was secured by running a “county” search at http://www2.state.tn.us/health/HCF3/Facilities_Listings/facilities.htm.¹⁴ By visiting the CMS website, advocates can access portions of recent survey reports to data on quality measures for specific nursing homes. See <http://www.medicare.gov/Nhcompare/Home.asp>.¹⁵

Presumably, Elder Law Attorneys, and their staff, have some knowledge regarding which nursing homes are providing quality care. This is because they should continue monitoring clients following a nursing home placement. Thus, Elder Law Attorneys should be a source of information, at least in terms of which nursing homes are responsive to family concerns. This information should be shared.

The Elder Law Attorney should also share information regarding how to contact the local Ombudsman (See Appendix B) for information regarding local track records. Ombudsmen exist to “to help residents and their families resolve questions or problems.” Ombudsmen should have current information regarding which homes are providing quality care. Information about the Ombudsman program and how they may be contacted is at the Tennessee Commission on Aging and Disability website, which is at <http://www.state.tn.us/comaging/ombudsman.html>.

¹⁴ Another “Tennessee” resource is the Tennessee Health Care Association website. See <http://www.thca.org/locatenh.htm>.

¹⁵ The nursing home quality measures come from resident assessment data that nursing homes routinely collect on all residents at specified intervals during their stay (referred to as the Minimum Data Set). The information collected pertains to the resident’s physical, and clinical conditions and abilities, as well as preferences and life care wishes. Residents have the right to access the complete survey reports. 42 C.F.R. § 483.10(g).

§ 4.2 Key Money and Waiting Lists:

When engaging in Medicaid Planning, some attorneys tell clients “Do not transfer all assets because applicant will require “key money” to enter private nursing home. Most nursing homes look for key money to cover six months to one year private pay.” *See, e.g.,* G. Mazart, *Government Benefits Eligibility for Custodial Care Coverage After the Omnibus Budget Reconciliation Act of 1993*, 231 PLI/Est 249 (1994); *see also* T. Begley & J. Jeffreys, *Representing the Elderly Client: Law & Practice* § 6.02 (Panel Publishing 1999, 2003). While this may be practical advice given industry practice, it is also illegal. Nursing homes that participate in the Medicare and/or Medicaid programs may not discriminate based on source of payment. *See* 42 C.F.R. § 483.12(c).¹⁶

Nursing homes sometimes request a financial statement or disclosure of the resident’s assets at the time of admission. This may be for the purpose of covert discrimination based on “ability to pay.” The practice should not be permitted or supported.¹⁷ In taking this position, this author recognizes that other Elder Law Attorneys, primarily those from non-*Linton* states,¹⁸ take different positions. NAELA members can access a listserv discussion thread on this topic by linking to <http://www.naela.org/private/memberslistarchive/index.cfm>, selecting the “search archive” option and searching the phrase “key money.”

Deposits and prepayment are prohibited if care is paid for by Medicare or Medicaid. “Medicare [and Medicaid] law prohibits Medicare [and Medicaid] providers from charging Medicare [and Medicaid] beneficiaries for services that are eligible for payment by Medicare [or Medicaid].” *See* The Center for Medicare Advocacy, *Deposits and Prepayments for Nursing Facility Care in Medicare and Medicaid*, XIV The Elderlaw Report 1 (March 2003). *See also* 42 C.F.R. § 447.15 (Medicaid is full payment).

In theory, every empty bed should be available for any person applying for admission to the nursing home. Nonetheless, facilities attempt to categorize beds into “Medicare,” “Medicaid,” and “Private pay” beds. This may be a form of payment discrimination and, as such, waiting lists may operate as an illegal admission barrier for Medicaid eligible residents. Carlson provides advice concerning how to respond when a facility employee claims no Medicaid bed is available. *See* Carlson, *supra*, § 3.04[1][a], at *Practice Note: Availability of “Medicaid bed.”*

¹⁶ “A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all individuals regardless of source of payment.” Throughout this paper, there are references to the Nursing Home Reform Act (42 U.S.C. § 1395i-3 and 42 U.S.C. § 1396r) and to the OBRA regulations (42 C.F.R. § 483). These statutes and regulations apply to all nursing homes that have entered into agreements to participate in the Medicare and/or Medicaid programs. *See Smith v. Chattanooga Medical Investors, Inc.*, 62 S.W.3d 178, 182 (Tenn. Ct. App. 2001) (“These Agreements make it obligatory upon the parties to comply with all federal and state Medicaid laws and regulations”).

¹⁷ Residents retain the right to manage their own financial matters, 42 C.F.R. § 483.10(c)(1), and have a right to privacy relating to their personal records. 42 C.F.R. § 483.10(e). The facility cannot require that a resident deposit their funds with the facility. 42 C.F.R. § 483.10(c)(1). In the author’s view, any arrangement designed to give the facility control over the resident’s assets before charges are incurred violates this regulation.

¹⁸ *Linton*, discussed below, is a Sixth Circuit decision out of Tennessee.

Often, the industry will use differentiated waiting lists to discriminate based on source of payment. That practice is illegal in Tennessee. One industry group explains the Tennessee rule as follows: “During the nursing facility selection process, you are likely to discover a policy unique to Tennessee - patient wait lists. In fact, you will find wait lists at most Tennessee facilities that accept Medicaid. The practice of maintaining prospective patient wait lists originates from a 1990 court case, *Linton v. Commissioner*,¹⁹ which resulted in a federal court ruling mandating Medicaid-participating facilities admit patients on a first-come, first-served basis.” See <http://www.thca.org/admission.htm>. In Tennessee, *Linton* prohibits any discrimination in the use of waiting lists.²⁰

§ 4.3 Evaluating the Nursing Home:

As Jim searches for the right nursing home, he will want to visit each prospective nursing home before agreeing to Mom’s admission. Information is available from CMS and other agencies that could assist Jim in that process. Among the tools available is a checklist Jim can use while visiting. The CMS checklist is attached as Appendix C (*See also* www.medicare.gov/nursing/checklist.pdf). Among the issues he should consider are the following:

A. Location, location, location.

Who is it that cares most about Mom and her well-being? The answer to that rhetorical question is “family.” Thus, one of the most important factors is whether the nursing home is located near family members who will visit Mom. If it is not, visits will become infrequent and Mom’s care will be guided by strangers.

B. Type of Facility Needed.

As stated above, Jim should try to determine Mom’s needs. This may be a seemingly impossible task for persons without a health care background if done alone. Jim should engage the health care community in discussions about what Mom needs. Then, Jim should ask prospective facilities whether they have the ability to meet Mom’s needs. He should insist on specific responses to his questions and should not accept general assurances.

C. Visit the Facility.

¹⁹ 779 F. Supp. 925 (M.D. Tenn. 1990), *aff’d*, 65 F.3d 508 (6th Cir. 1995).

²⁰ “We initially address the propriety of the first-come, first-serve admission requirement. Defendant-intervenors, without more, claim that this requirement is overbroad. We disagree. The record shows there are more applicants than there are nursing facility beds. The first-come, first-serve policy limits preferences among applicants to those based on medical needs. Defendant-intervenors argue that the rule unnecessarily precludes an exception for private-pay preference. Such an exception would swallow the rule, however. Under such an exception, providers could provide even fewer beds for Medicaid patients than they did under the limited bed policy.” *Linton*, 65 F.3d., at 515.

A personal inspection of the facility is critical. Jim should use a checklist, such as Appendix C so he notices more than cosmetic appearance. Perhaps the single most important factor in determining the quality of care Mom receives is the quality of the staff. Are they friendly? Are they responsive to residents and families already in the facility? Are the people there happy?

Jim will need to spend enough time in the facility, visiting on more than one occasion, to make that determination. Even after admission, Jim will also want to continue observing the nursing home to ensure that Mom gets the care she needs. He should not always visit at the same time, allowing staff to make Mom presentable. He should visit Mom at varying times so that he will have a more complete view of what is occurring at all times of the day.

After Jim locates an appropriate nursing facility, the Elder Law Attorney may assist the family in negotiating appropriate terms and in reviewing admission documents.²¹ The resident and her family should understand what services and care the nursing home intends to provide and, if any necessary services will not be provided, that should be addressed as well. Some nursing homes now attempt to “educate” families regarding what is called the dying process. Health Care Advocates should not accept this as a pretext for the provision of sub-standard care and, instead, should work with both health care providers and family members to develop realistic expectations regarding the resident’s condition and what treatment options are available.

It is also helpful to remind family members that they are the first and best link to better care. “Nursing home residents often lose a sense of who they are because no one knows them. You’re the link to the past, to your relative’s identity. You can reinforce your relative’s identity in your interactions with your relative and with staff.” *Nursing Homes: Getting Good Care There, supra*, 17.

§ 5.0 The Nursing Home Admission:

A nursing home admission requires a doctor’s order. 42 C.F.R. § 483.20(a) & § 483.40; Tenn. Comp. R. & Regs. 1200-8-6-.04(15). While this appears to be a simplistic beginning point, it is not because often family members often feel like they have failed Mom when she is placed in a nursing home. It is important to remind them that a nursing home placement is a medical, not a moral, decision. Thus, while Jim cannot take care of Mom at home, by admitting Mom, the nursing home agrees that it can. Tenn. Comp. R. & Regs. 1200-8-6-.05(1)(c). This should give Jim comfort.

The nursing home is required to provide notices about the services available, its charges, as well as other information. Jim should keep everything the facility gives him, including brochures,

²¹ Although the focus here is not asset protection planning, it is worth noting that one way to reduce to the cost of nursing home care is by negotiating a better rate. See T. Takacs, *Elder Law in Tennessee, supra*, Chapter 7 (to be discussed in next supplement).

advertising, etc. This information may be helpful later if there is a dispute over care or over the cost of care.

§ 5.1 Pre-admission Notices:

All nursing homes are required to provide certain pre-admission notices to residents. Among the information nursing homes must provide is the following:

- (1) The name of the facility administrator, the names, addresses and telephone numbers of any entity under contract to manage the facility, the state survey and certification agency, the state licensure office, the state ombudsman for the region where the facility is located, the protection and advocacy network, and the state Medicaid fraud control unit; and a statement that the resident may file a complaint with the state survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and noncompliance with the advanced directive requirements. T.C.A. § 68-11-254.
- (2) (a) Prior to the admission of a resident to a nursing home or prior to the execution of a contract for the care of a resident in a nursing home (whichever occurs first), the nursing home shall make the following written disclosures to the resident, the resident's authorized representative and the resident's next of kin, if any:
 - (1) The facility's basic daily or monthly rates;
 - (2) A description of all facility services, including those offered on an as-needed basis, and related charges, including any extra charges for services not covered by third party governmental programs or by the facility's basic daily or monthly rate;²²
 - (3) The right of the resident, the resident's authorized representative, and the resident's authorized next of kin to review the resident's medical and financial records and the resident's right to have such records be kept confidential as to inspection by other third parties, unless the resident has given such parties written consent or they are otherwise authorized by law to make such inspection;²³
 - (4) A copy of the policies or procedures required for the protection of residents' rights by this chapter or by the regulations of the board for licensing health care facilities or by any federal agency with jurisdiction over the facility; and
 - (5) The address and telephone numbers of the department of health, the local long term care ombudsman and local legal services organizations funded under the Older Americans Act that offer services without charge to facility residents, along with a brief description of the services provided without charge by such agencies. TCA § 68-11-910.

Notices required by Federal regulations, 42 C.F.R. § 483.10(b), include the following:

- (1) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. ... Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing;
- (5) The facility must--

²² This disclosure links with the Elder Law Attorney's counsel regarding Medicaid Planning.

²³ This disclosure links with counsel regarding self determination.

(i) Inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of--²⁴

(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;

(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and

(ii) Inform each resident when changes are made to the items and services specified in paragraphs (5)(i) (A) and (B) of this section.

(6) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

(7) The facility must furnish a written description of legal rights which includes--

(i) A description of the manner of protecting personal funds, under paragraph (c) of this section;

(ii) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels;

(iii) A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and

(iv) A statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

(9) The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

§ 5.3 Reviewing the Admissions Agreement:

Documentation pertaining to the payment agreement between the nursing home and the resident shall be completed prior to admission. A copy of the documentation shall be given to the resident and the original shall be maintained in the nursing home records. *See* Tenn. Comp. R. & Regs. 1200-8-6-.04(15).

²⁴ This is often a pre-text to inquire into the resident's financial condition.

The Tennessee regulations requiring documentation of a payment agreement imply that an admissions agreement is necessary. The admissions agreement outlines those duties the nursing home assumes beyond its obligations under Federal and State law. Typically, the admission agreement states that the nursing home will provide necessary care and services in return for compensation. Elder Law Attorneys should review agreements for illegal provisions such as third party guarantees, provisions that prohibit asset transfers (Medicaid Planning), and arbitration agreements. Illegal contracts are void and unenforceable. *See, e.g., Empiregas Inc. of Ardmore v. Hardy*, 1987 WL 7012 (Tenn. Ct. App. Feb. 27, 1987) (in the context of an employment agreement).

As part of the admissions process, a nursing facility must:

1. not require individuals applying to reside or residing in the facility to waive their rights to benefits under the Medicare or Medicaid program (42 C.F.R. § 483.12(d)(1)(i));
2. not require oral or written assurance that such individuals are not eligible for, or will not apply for, benefits under Medicare and Medicaid (42 C.F.R. § 483.12(d)(1)(ii));
3. prominently display in the facility written information, and provide oral and written information, about how to apply for and use such benefits and how to receive refunds for previous payments covered by such benefits (42 C.F.R. § 483.10(b)(10));
4. not require a third-party guarantee of payment to the facility as a condition of admission to, or expedited admission to, or continued stay in, the facility (42 C.F.R. § 483.12(d)(2); and
5. in the case of a Medicaid recipient, not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the state plan, any gift, money, donation, or other consideration as a precondition of admitting, or expediting the admission of, the individual to the facility or as a requirement for the individual's continued stay in the facility (42 C.F.R. 483.10(c)(8); 42 C.F.R. § 483.12(d)(3).

See also 42 U.S.C. § 1395i-3(c)(5)(A)(i)(I)-(III), (A)(ii); § 1396r(c)(5)(A)(i)(I)-(III), (A)(ii), (A)(iii).

A checklist of provisions Jim should review includes the following:

- Services included in the daily rate;
- Services for which there is an extra charge;
- Source of payment, such as Medicare or Medicaid;
- Cost to resident;
- Terms of the security deposit, if any;
- Resident's rights and grievance procedure;
- Additional provisions agreed to by both parties;
- Designation of patient representative, if desired by resident.

When he signs the admission agreement, Jim should have:

- A receipt for money deposited in the patient's trust fund, if any;
- A receipt for the security deposit, if any;
- A receipt for advanced payment;
- A copy of the home's residents' rights policy and grievance procedure;
- A copy of every other document he signed at admission.

Jim should look to make certain the following are attached to the contract:

- Signed inventory of resident's clothing and personal belongings;
- A copy of the patient representative form, if approved;
- A copy of any additional agreements he made with the home;
- An Ombudsman Program brochure.

§ 5.4 Prohibitions on Medicaid Planning:

Although the regulations are cited above, recent trends in industry practice make it advisable to emphasize resident rights concerning Medicaid Planning. More and more often, nursing homes request (or require) assurances that a resident has sufficient assets to private pay. Those requests violate the OBRA regulations. In short, nursing homes may not prohibit Medicaid Planning; to the contrary, “[a] nursing facility which has entered into a provider agreement with the state **has a duty to assist a resident or applicant in applying for Medicaid eligibility and in applying for Medicaid-reimbursed Nursing Facility care.** Rule 1200-13-1-.10(2)(i).” (emphasis added) *See Smith v. Chattanooga Medical Investors, Inc.*, 62 S.W.3d 178 (Tenn. Ct. App. 2001).²⁵ Until the nursing home provides services requiring payment, any restraint on use of the resident’s funds violates 42 C.F.R. § 483.10(c)(1). Nursing homes may not require residents to waive their right to Medicare and/or Medicaid. 42 C.F.R. § 483.12(d)(1)(i). The facility may not require oral or written assurances that a resident will not apply for Medicaid. 42 C.F.R. § 483.12(d)(1)(ii). In fact, the OBRA regulations place an affirmative duty on facilities to advise residents concerning the eligibility rights and concerning how to preserve the CSRA. 42 C.F.R. § 483.10(b)(7)(ii).

§ 6.1 The Assessment:

“Residents need to help staff get to know them. Resident’s should tell staff their needs and hopes and how they feel.” *Nursing Homes: Getting Good Care There, supra*, 40. A complete assessment goes beyond medical needs and includes strengths (physical, social, spiritual),

²⁵ The regulation provides as follows: “A Nursing Facility that has entered into a provider agreement with the Department shall assist a resident or applicant as follows: 1. The Nursing Facility shall assist a Nursing Facility resident or an applicant for admission in applying for Medicaid eligibility and in applying for Medicaid-reimbursed Nursing Facility care. This shall include assistance in properly completing all necessary paperwork and in providing relevant Nursing Facility documentation to support the PreAdmission Evaluation. Reasonable accommodations shall be made for an individual with disabilities or, alternatively, for a Designated Correspondent with disabilities when assistance is needed with the proper completion and submission of a PreAdmission Evaluation.” Tenn. Comp. R. & Regs. 1200-13-1-.01(2)(i).

customary routines, preferences, abilities. Id. Family can assist in this process.

“Assessment is the first step in the nursing process and includes the systematic collection, verification, organization, interpretation, and documentation of [resident] data.” L. White, *Documentation & the Nursing Process* 15 (Thomson-Delmar 2003). Proper assessment is critical because the care plan and treatment hinge on identification of the resident’s needs. The assessment must take the resident’s overall condition into account, including physical, mental and psycho-social needs (42 C.F.R. § 483.25), and must be performed by a multi-disciplinary staff.²⁶ Family should provide input to ensure that the facility gets a “whole picture” of the resident. Otherwise, Mom may simply be the new resident in “Room 220 with diabetes.” If, instead, the staff sees Mom as the person in Room 220 with her present strengths and needs and as an individual with particular likes, dislikes, customs habits, or patterns in her daily life, her care will improve.

Federal regulations, specifically 42 C.F.R. §483.20, provide:

The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. ... A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State.²⁷ The assessment must include at least the following:

- (i) Identification and demographic information.
- (ii) Customary routine.
- (iii) Cognitive patterns.
- (iv) Communication.
- (v) Vision.
- (vi) Mood and behavior patterns.
- (vii) Psychosocial well-being.
- (viii) Physical functioning and structural problems.
- (ix) Continence.
- (x) Disease diagnoses and health conditions.
- (xi) Dental and nutritional status.
- (xii) Skin condition.
- (xiii) Activity pursuit.
- (xiv) Medications.
- (xv) Special treatments and procedures.
- (xvi) Discharge potential.
- (xvii) Documentation of summary information regarding the additional assessment performed through the resident assessment protocols.
- (xviii) Documentation of participation in assessment.

The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.

²⁶ Tenn. Comp. R. & Regs. 1200-8-6-.05(3)(a).

²⁷ Two primary documents are used in performing the resident assessment. First, the Minimum Data Set (MDS) is a comprehensive form that charts the resident’s overall condition. If certain risk factors are identified, then a Risk Assessment Protocol (RAP) is triggered and a risk assessment instrument is completed.

Assessment is a continuing process. Assessments must accurately reflect the resident's status. 42 C.F.R. § 483.20(g).²⁸ They must occur quarterly, annually, and within 14 days after a significant change in condition. 42 C.F.R. § 483.20(b)(2) and (c). The facility must use the assessments to develop, review and revise the resident's plan of care. 42 C.F.R. § 483.20(d).

§ 7.1 The Care Plan:

42 C.F.R. § 483.20(k)(1) provides:²⁹

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following (I) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under Sec. 483.25

The OBRA regulations give the resident and family members the right to be involved in and to participate in developing a meaningful and effective care plan. 42 C.F.R. § 483.20(k)(2)(ii). Family members, and residents themselves where possible, should avail themselves of this right because it is almost certain that the resident will get better care, will enjoy a better quality of life in the nursing home and will maintain more independence when the plan is customized to meet the resident's individual needs and preferences.

What happens in a care plan meeting? A multi-disciplinary committee of staff comes together to discuss the progress or problems that Mom has experienced since the last care planning meeting. If problems need to be addressed, there should be discussion based on the staff's knowledge of the resident as well as information from her written record. This is an ideal time for family members to raise concerns and request that they be resolved. Jim should be asked and should give his opinions regarding any issue being discussed. If, for example, Mom isn't eating and is losing weight, Jim should raise the issue and suggest any alternatives (e.g., maybe Mom doesn't like Peas and carrots). Treatment options and alternatives should be discussed before they are implemented.

Finally, at the meeting, goals for the resident will be agreed upon and reduced to writing in the resident's record. 42 C.F.R. § 483.24(k)(1). The goals must be measurable and timetables should be set to meet Mom's needs. If the care plan is done properly, at the next meeting, Jim and the staff can look back and see whether progress is being made toward these goals and, if not, whether the care plan should be modified. Jim should not hesitate to ask why goals were not, and plans put in place which will assure that the goals are met.

²⁸ Tenn. Comp. R. & Regs. 1200-8-6-.06(5)(b).

²⁹ See also T.C.A. § 68-11-901(10); Tenn. Comp. R. & Regs. 1200-8-6-.12(1)(m) & (y).

The care plan is a critical document because it serves as the foundation for all treatment Mom will receive. 42 C.F.R. § 483.20(k)(3)(ii). If Jim is uncomfortable with the care planning process, then the Elder Law Attorney should consider going with him, or assigning a knowledgeable staff member to attend the meeting with him. This may not be necessary every time, but it may help him become involved in the process and may educate the facility to the fact that Jim takes Mom's care seriously.

§ 7.2 Right to Information Necessary to Participate in Care Plan:

The patient's right to self determination is discussed above and, with it, there is a discussion concerning access to information. The same information is necessary to participate in the care plan. 42 C.F.R. § 483.10(b)(2), (3), (4).

In addition, the facility must keep family apprised on changes in the resident's condition. 42 C.F.R. § 483.10(11) requires:

(11) Notification of changes.

(i) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is--

(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;

(B) A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);

(C) A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or

(D) A decision to transfer or discharge the resident from the facility as specified in § 483.12(a).

§ 7.3 The Care Plan is the Contract

In 1997, H. Kennard Bennett presented his paper, *Nursing Home: The Care Plan is the Contract* (NAELA Symposium 1997). There, Bennett argued that the care plan links into the admission agreement and is part of the contract. His reasoning hinges on the consideration the nursing home provides in its admission agreement. Typically, the nursing home promises, in some form, to provide "general nursing services, room, board and other related services." Given the overlay of the Nursing Home Reform Act and the nursing process itself, this means the nursing home is

promising to deliver treatment for assessed needs as provided for in the care plan. Bennett counsels that the Elder Law Attorney should be prepared to attend care plan meetings and participate meaningfully. This requires securing the MDS and any prior care plans prior to attending, making a list of issues and concerns, and preparing an agenda for discussion with nursing home staff. At the care plan meeting, review the accuracy of the assessment, see that specific goals are set to meet the resident's needs, identify the persons responsible for meeting the resident's needs, and clarify when the next routine evaluation will occur and who should be contacted in the interim if new issues arise.

§ 8.0 Issues Related to Treatment

42 C.F.R. § 483.25 provides: **Each resident must receive and the facility must provide** the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. (emphasis added).

After the care plan is developed, it must be implemented.³⁰ The care and services provided must meet professional standards of quality and must be provided consistent with the plan of care. 42 C.F.R. § 483.20(k)(3). The facility must ensure that a resident is given the appropriate treatment and services to maintain or improve his or her ability to engage in the activities of daily living. 42 C.F.R. § 483.25(a)(2). Care must be provided in a manner that enhances the resident's quality of life and promotes dignity:

A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life. (a) Dignity. The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. 42 C.F.R. § 483.15.

Sometimes, nursing homes do not provide appropriate care. The focus of the discussion here is on improper care and treatment. Where inadequate care is provided, residents may be victims of abuse. To evaluate those situations, Elder Law Attorneys should recognize “signs of abuse.”³¹

T.C.A. § 68-11-901(21) provides that: “Every nursing home resident/patient has the following minimum rights ... To be free from willful abuse or neglect, as these terms are defined by T.C.A. § 71-6-102.” “Abuse or neglect” means the infliction of physical pain, injury, or mental anguish, or the deprivation of services by a caretaker which are necessary to maintain the health and welfare of an adult or a situation in

³⁰ “Implementation involves the execution of the nursing care plan derived during the planning stage.” White, *supra*, 55.

³¹ For a discussion of Elder abuse in institutional settings, see C. Hawes, Ph.D., *Elder Abuse in Residential Long-Term Care Facilities: What is Known About Prevalence, Causes, and Prevention*, Testimony Before the U.S. Senate Committee on Finance (June 18, 2002); nonetheless, institutional Elder abuse comprises a small percentage of substantiated Elder abuse cases. *The National Elder Abuse Incidence Study: Final Report* (1998), available at http://www.aoa.gov/eldfam/Elder_Rights/Elder_Abuse/ABuseReport_Full.pdf, indicates that most Elder abuse is committed by family members. Thus, the Elder Law Attorney who is hyper critical of nursing homes, to the exclusion of other perpetrators, may be overlooking a more serious community problem.

which an adult is unable to provide or obtain the services which are necessary to maintain that person's health or welfare. Nothing in this part shall be construed to mean a person is abused or neglected or in need of protective services for the sole reason that the person relies on or is being furnished treatment by spiritual means through prayer alone in accordance with a recognized religious method of healing in lieu of medical treatment; further, nothing in this part shall be construed to require or authorize the provision of medical care to any terminally ill person if such person has executed an unrevoked living will in accordance with the provisions of the Tennessee Right to Natural Death Law, compiled in title 32, chapter 11, and if the provisions of such medical care would conflict with the terms of such living will. T.C.A. § 71-6-102(1). See also Tenn. Comp. R. & Regs. 1200-8-6-.01(35).³²

The following list indicates signs for recognizing abuse. It is not intended to be exhaustive.³³

Physical Abuse Indicators:

- Bruises and discoloration on inner arm/thigh, thumb/finger prints, choke marks, presence of old and new bruises in the same place, different colored bruises, and suspicious shapes caused by coins, cords or belts used as restraints.
- Scratches, cuts, pinch marks, cigarette burns, rope burns, and fractures.
- Physical injury on head, scalp or face, e.g. black eye.
- Bruises around breast or genital areas, unexplained vaginal or anal bleeding, or torn, stained and bloody under clothing.
- Physical restraint use not ordered by a doctor and used for the convenience of care provider, e.g., persons tied in bed, strapped into wheelchairs while slumping over or sitting out of alignment, etc.
- Drowsiness, dry and cracked lips, drooling, vacant stare from over- medication.

Neglect Indicators:

- Poor hygiene, e.g., unkempt appearance, stained or torn clothes.
- Dirty or uncut finger or toe nails.
- Inadequate dental hygiene.
- Signs of feces on resident or in bathroom and smell of urine.
- Person lying in urine or feces.
- Unexplained weight loss, malnutrition and dehydration.
- Persons left unattended on toilet.
- Bruising or fractures from rough handling or frequent falls due to lack of attention.
- Bedsores on buttocks, heels, elbows, shoulder blades, etc.
- Staffing problems in care facilities lead to neglect, e.g., limited number of staff on nights and weekends, staff inadequately trained or experienced for assignment, and high staff turnover.

Behavioral Abuse Indicators:

- Fear

³² Each resident has the right to be free from abuse. 42 C.F.R. § 483.13(b). The terms “abuse” and “neglect” are also defined in 42 C.F.R. § 488.301. For example, “neglect” means “failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.”

³³ Signs and symptoms of abuse are reviewed on the National Center on Elder Abuse website at <http://www.elderabusecenter.org/default.cfm?p=basics.cfm>.

- Helplessness/Resignation
- Implausible Stories
- Anger
- Withdrawal
- Hesitation to Talk Openly
- Confusion or Disorientation
- Denial
- Depression
- Anxiety
- Agitation
- Non-Responsiveness

Relational Abuse Indicators:

- The elder is not given the opportunity to speak for him/herself.
- Family or care providers restrict activity, outside contacts.
- Family or care providers do not allow the elder to be alone with anyone.
- Family and/or care providers provide conflicting reports on condition of the elder.
- There are suspicions of substance abuse by caregiver.

In reviewing potential abuse cases, the Elder Law Attorney should keep in mind that many of these signs and symptoms occur where abuse is absent. Thus, the health advocate should always be ready to ask “why” symptoms of abuse are present. If a satisfactory explanation is provided, then monitoring may be the only course of action necessary. If no explanation is given, or if the explanation is inadequate or improbable, then a referral to Adult Protective Services or to the District Attorney may be in order. A referral to litigation counsel may also be appropriate.

§ 8.1 Staffing:

Nursing home residents are frail and require assistance with ADLs. Their basic needs (physiologic) must be met before higher-level needs can be met. White, *supra*, 24. Inadequate staffing, invariably, impairs the facility’s ability to meet basic needs and leads to inadequate or substandard care. If the nursing facility accepts Medicare and/or Medicaid, then federal regulations do not permit the home to set an arbitrary “minimum staffing” level. Further, “state minimum staffing levels” are inconsistent with the federal regulations. The federal regulations require: “The facility *must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident*, as determined by resident assessments and individual plans of care.” 42 C.F.R. § 483.30 (emphasis added); *see also* Tenn. Comp. R. & Regs. 1200-8-6-.06(4)(d). Thus, federal and state regulations are tied to individual resident needs and overall acuity levels within the home. In Tennessee, the administrator is responsible for ensuring appropriate staffing levels. Tenn. Comp. R. & Regs. 1200-8-6-.04(1).³⁴

³⁴ “The administrator shall assure the provision of appropriate fiscal resources and personnel required to meet the needs of the residents.”

State *minimum* staffing levels apply without regard to acuity levels. Tennessee Code, Chapter 1200-8-6-.04 requires a minimum of 2.0 hours of direct care to each resident every day, including 0.4 hours of licensed nursing personnel time. The number of direct nursing hours required shall be calculated according to the following formula:

residents x # nursing hours required per resident day = total direct nursing hours required
residents x # licensed nursing hours required per resident day = total licensed nursing hours required
divide the total hours required by the number of hours worked by a full-time person (usually 8)
At least 1 licensed nurse on duty at all times.

If the nursing service is under the direction of an LPN, an RN must be available on the nursing home premises to consult, review, and advise on the quality of nursing care for at least 48 weeks in each calendar year. The RN consultant must be on the premises at least 8 hours each week (12 hours/week in homes with 51+ beds). In facilities with 50 beds or less, the DON, in addition to nursing administrative and supervisory responsibilities, may participate in general nursing duties and patient care activities not to exceed 50% of his/her working hours.³⁵

§ 8.2 Diabetic Care:

A syndrome characterized by hyperglycemia with repeated fasting blood glucose levels > 125 mg/dL (> 6.9 mmol/L) or any postprandial level > 200 mg/dL (>11.1 mmol/L) resulting from absolute or relative impairment of insulin secretion and/or insulin action. The Merck Manual of Geriatrics, Third Edition 624 (Merck & Co. 2000).

Improper management of diabetes can result in tissue damage, nutritional compromise, other disorders, and death. Residents with diabetes should be on a diabetic diet (42 C.F.R. § 483.25(i)(2)), should have blood glucose levels checked regularly, and should otherwise be appropriately monitored.

Diabetic assessment includes a history and physical examination. M. Burke & J. Laramie, *Primary Care of the Older Adult: A Multidisciplinary Approach* 273 (Mosby 2000). Laboratory testing should include fasting plasma glucose, glycosylated hemoglobin level, fasting lipid profile, serum creatine, urinalysis, test for microalbuminuria, and electrocardiogram. *Id.* Effective treatment is aimed at achieving optimal blood glucose levels and decreasing complications. *Mastering Geriatric Care* 248 (Springhouse 1997).³⁶ Treatment is individualized, depending on the resident's condition and ability to participate in a treatment plan. It may

³⁵ For staffing guidelines in other states, see http://www.nccnhr.org/govpolicy/51_162_468.cfm#federaland.

³⁶ Complications can include hypoglycemia (slow cerebration, dizziness, weakness, pallor, tachycardia, diaphoresis, seizures, and coma), urinary incontinence, abdominal discomfort, neurologic abnormalities and stupor. *Mastering Geriatric Care, supra*, 249-250.

include a glucose monitoring,³⁷ a therapeutic diet, exercise, and insulin therapy. *Primary Care of Older Adults, supra*, at 274.

Nurses should look for complications such as cardiovascular, coronary artery or peripheral vascular impairment, diabetic neuropathy and urinary tract infection. *Mastering Geriatric Care, supra*, 250. Skin care should be provided meticulously and all skin injuries should be treated. *Id.*

§ 8.3 Nutrition:

Nutrition. Based on a resident's comprehensive assessment, the facility must ensure that a resident—(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. 42 C.F.R. § 483.25(i).³⁸

When nutrition is inadequate, the resident's overall health condition will deteriorate and lead to other problems, such as pressure ulcers. Signs of inadequate or declining nutrition status include:³⁹

- Weight loss of ten pounds or more.⁴⁰
- Serum albumin below 3.5 g/dl
- Underweight or overweight⁴¹
- Nutrition related disorders
- Inappropriate food intake
- Triceps skinfold <10th percentile or > 95th percentile
- Change in functional status
- Mid-arm muscles circumference
- Cachexia
- Bilateral edema
- Muscle wasting

Other, lay observations that family may wish to look for include:

³⁷ Unless otherwise ordered by a physician, serum glucose or glycosylated hemoglobin levels should be reviewed every six to eight weeks. *Mastering Geriatric Care, supra* 249.

³⁸ "Therapeutic diet" means a diet ordered by a physician as part of treatment for a disease or clinical condition, to eliminate or decrease certain substances in the diet (e.g. sodium) or to increase certain substances in the diet (e.g., potassium), or to provide food the resident is able to eat (e.g., a mechanically altered diet). *See Guidance to Surveyors – Long Term Care Facilities Guide to Survey Tag Numbers*, F326.

³⁹ *See Primary Care for Older Adults, supra*, 65.

⁴⁰ Weight loss of 5% during 1 month, 7.5% during 3 months, or 10% during 6 months is significant and calls for nursing intervention. Weight loss of more than those amounts is deemed severe. *See Guidance to Surveyors – Long Term Care Facilities Guide to Survey Tag Numbers*, F325 and F326.

⁴¹ Body mass will indicate whether a resident is underweight or overweight. A more simplistic approach uses the following generalization: For men, 106 pounds for the first 5 feet of height, plus 6 pounds for each additional inch; for women, 100 pounds for the first five feet of height, plus 5 pounds for each additional inch. *See Primary Care for Older Adults, supra*, 66.

- Pale skin
- Dull eyes
- Swollen lips, gums or tongue with scarlet or magenta hue
- Poor skin turgor
- Ill-fitting clothes
- Loose dentures
- Swallowing problems
- Lack of meal variety
- Lack of assistance with meals
- Rushed mealtimes
- Difficulty eating
- Changes in bowel habits

§ 8.4 Hydration:

Hydration. The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. 42 C.F.R. § 483.25(j).

Dehydration is the most common fluid and electrolyte disturbance in the elderly. *See Primary Care for Older Adults, supra*, 71. Most people require 30ml of fluid per kilogram of body weight unless a fluid restriction is indicated. *Id.*⁴² Abnormal laboratory values may indicate dehydration (e.g., elevated hemoglobin and hematocrit, potassium, chloride, sodium, albumin, transferrin, blood urea nitrogen (BUN), or urine specific gravity). Signs and symptoms of dehydration include:

- Coma/decreased sensorium
- Fluid loss and increased fluid needs (e.g., fever)
- Fluid restriction secondary to renal dialysis
- Functional impairments that make it difficult to drink, reach fluids, or communicate fluid needs
- Dementia in which resident forgets to drink or forgets how to drink
- Refusal of fluids or thirst
- Sunken eyes
- Dry or cracked lips
- Dry skin and mucous membranes
- Change in mental status

⁴² “Sufficient fluid” means the amount of fluid needed to prevent dehydration (output of fluids far exceeds fluid intake) and maintain health. The amount needed is specific for each resident, and fluctuates as the resident’s condition fluctuates (e.g., increase fluids if the resident has fever or diarrhea. *See Guidance to Surveyors – Long Term Care Facilities Guide to Survey Tag Numbers*, F327. A general guideline is to multiply the resident’s body weight in kg times 30cc (2.2 pounds = 1 kg), except for residents with renal or cardiac distress. An excess of fluids can be detrimental for these residents. *Id.*

- Strong urine odor
- Constipation

§ 8.5 Medications:

Unnecessary drugs -- (1) General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: (i) In excessive dose (including duplicate drug therapy); or (ii) For excessive duration; or (iii) Without adequate monitoring; or (iv) Without adequate indications for its use; or (v) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (vi) Any combinations of the reasons above.⁴³

(2) Antipsychotic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (i) Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record;⁴⁴ and (ii) Residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.⁴⁵

Medication Errors --The facility must ensure that-- (1) It is free of medication error rates of five percent or greater; and (2) Residents are free of any significant medication errors.⁴⁶ 42 C.F.R. § 483.25(l) & (m).

An overdose, depending on the person and the drug involved, can lead to serious and deadly consequences.⁴⁷ Certain drugs are more likely than others to cause serious reactions when their dosage recommendations are exceeded. The combination of access to drug products that are designed for adults and a person's diminutive size make overdoses in frail persons particularly dangerous.

Signs and symptoms of medication problems can include:

- Change in mental status
- Drowsiness
- Dizziness
- Weakness
- Rashes
- Medication interactions

⁴³ See *Guidance to Surveyors – Long Term Care Facilities Guide to Survey Tag Numbers*, F329.

⁴⁴ See *Guidance to Surveyors – Long Term Care Facilities Guide to Survey Tag Numbers*, F330.

⁴⁵ See *Guidance to Surveyors – Long Term Care Facilities Guide to Survey Tag Numbers*, F331.

⁴⁶ See *Guidance to Surveyors – Long Term Care Facilities Guide to Survey Tag Numbers*, F332 and F333.

⁴⁷ “Significant medication error” means one which causes the resident discomfort or jeopardizes his or her health and safety. See *Guidance to Surveyors – Long Term Care Facilities Guide to Survey Tag Numbers*, F333.

- Poor appetite

§ 8.6 Pressure Ulcers:

Pressure sores. Based on the comprehensive assessment of a resident, the facility must ensure that-- (1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and (2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. 42 C.F.R. § 483.25(c).⁴⁸

“The intent of this regulation is that the resident does not develop a pressure sore while in the facility.” *See Guidance to Surveyors – Long Term Care Facilities Guide to Survey Tag Numbers*, F314. Pressure ulcers, also known as skin ulcers, bedsores, decubitus ulcers, dermal ulcers, or pressure sores, typically occur in areas where bones project outward on the skin, such as the lower back, buttock area, and ankles. Simply put, pressure plus time results in pressure ulcers. They develop when the blood flow to these areas is reduced or cutoff. Such an interruption in blood flow often occurs in bedridden or otherwise immobilized people. When pressure (from a bed, gurney, wheelchair, or other object) is applied to a susceptible area for a long period of time, the blood supply that nourishes the skin cells is discontinued and the skin subsequently dies. This dying tissue may become a bedsore.

Bedsore are more likely to occur in immobilized people whose skin is irritated by poor bedding conditions including extended contact with feces and / or urine. The best treatment is to prevent bedsore from occurring in the first place. Shifting the immobilized person as often as every two hours may also prevent bedsore. Pressure relieving mattresses may help.

Pressure ulcers are preventable.⁴⁹ Prevention is accomplished by early identification of individuals at risk and implementation of interventions to reduce or eliminate these risks. Key elements of assessment to include are nutritional status, assessment for impediments to mobility, medication review especially for drugs increasing somnolence, and identification of causes of urinary and fecal incontinence. Strategies must be in place to avoid direct pressure to bony prominences, as well as direct contact of two body surfaces.

Turning and positioning every 2 hours with the use of pillows for support is essential. Alternating pressure mattresses, foam wedges and pads facilitate pressure reduction. An overbed trapeze affords bed ridden patients a greater degree of mobility. The use of doughnuts, sheepskin pads and egg crates is discouraged because they relieve only surface pressure while providing a false sense of security. Shear force results when friction between skin and a stationary surface holds the soft tissue in place while gravity pulls the axial skeleton down. Discourage the bed or

⁴⁸ *See Guidance to Surveyors – Long Term Care Facilities Guide to Survey Tag Numbers*, F314.

⁴⁹ Because pressure ulcers are devastating and are usually preventable, they are often a subject of litigation. *See, e.g., A. Clement, Litigating the Pressure Sore Case Against a Nursing Home*, 12-Fall NAELA Quarterly 8 (1999).

chair bound patient from sitting with head elevated more than 30 degrees except for short periods of time.

Pressure ulcers occur most commonly on sacrum, hips, buttock, heels and/or lateral malleoli. Staging techniques are designed to identify the degree of tissue involvement. Staging is illustrated on the following table.

Stage	Characteristics	Treatment
I	Non-blanchable erythema of intact skin	Avoid massage and pressure to involved area. Implement all relevant preventive measures. Film or hydrocolloid dressing may be needed based on location of ulcer. Continue to assess for risk factors.
II	Partial thickness skin loss with epidermal involvement (may appear as abrasion, blister or shallow crater).	Treatments as outlined above with addition of petroleum gauze or semipermeable dressing to prevent dryness and protect healthy tissue
III	Full thickness skin loss into subcutaneous tissue	Surgical or chemical debridement of necrotic tissue; cleanse wound with normal saline or whirlpool therapy; dress wound to ensure that ulcer tissue is kept moist while surrounding tissues are kept dry. Hydrocolloid dressings may be utilized. Consider use of specialized beds (low air loss or air-fluidized). Treat infection if present. Continue to assess for risk factors
IV	Full thickness skin loss with extension beyond the deep fascia and involvement of muscle, bone, tendon or joint space	Treatment as outlined above. Wound packing may be needed based on the depth of wound. Continue to assess for risk factors.

(Information in this section has been culled from various sources on pressure ulcers. For more information concerning their development and prevention, *see* the *National Pressure Ulcer Advisory Panel* website, at <http://www.npuap.org/Default.htm>).

§ 8.7 Miscellaneous Issues:

Elopement (accidents):

Accidents. The facility must ensure that-- (1) The resident environment remains as free of accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. 42 C.F.R. § 483.25(h).

Each year, vulnerable adults die from exposure after walking-away from their homes, as well as their assisted living and nursing home residences. Long-term care residents and family members with Alzheimer's disease, dementia, those who are confused, or who tend to wander are especially vulnerable. It is not enough to simply watch over them. Much like children - if you turn your back for a few minutes, they are gone. Think they are asleep or occupied in an activity, before you know it - they are gone. When vulnerable adults do walk-away they are usually not dressed appropriately for the weather conditions. They could be in jeopardy within hours, even minutes.

In Tennessee, “where a special relationship exists between the defendant and a person who is foreseeably at risk from danger, . . . the defendant is under an affirmative duty to take whatever steps are reasonably necessary and available to protect an intended or potential victim.” *Limbaugh v. Coffee Medical Center*, 59 S.W.3d 73, 79 (Tenn. 2001). Thus, precautions are in order where there is a risk of elopement.

The same regulation applies to falls and other accidents.

Atmosphere:

The facility must provide-- 1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible;(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;(3) Clean bed and bath linens that are in good condition;(4) Private closet space in each resident room, as specified in § 483.70(d)(2)(iv) of this Part; (5) Adequate and comfortable lighting levels in all areas; (6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71-81° F; and (7) For the maintenance of comfortable sound levels. See 42 C.F.R. § 483.15(h).

Problems include:

- Unclean residents and sanitation problems
- Unpleasant odors
- Hurried staff
- Slow response to nurse call lights

Decline in Mobility:

A resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to—(i) Bathe, dress, and groom; (ii) Transfer and ambulate; (iii) Toilet; (iv) Eat; and (v) Use speech, language, or other functional communication systems. 42 C.F.R. § 483.25(a)(1).

Sometimes therapy is discontinued after Medicare dollars are exhausted. Family are told that therapy cannot be provided because Medicare will not pay for it. This practice is illegal. Specifically, 42 C.F.R. § 483.25(e) provides:

Range of motion. Based on the comprehensive assessment of a resident, the facility must ensure that-- (1) A resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and (2) A resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. *See also* 42 C.F.R. § 483.45(a).

Problems include:

- Difficulty getting up from a chair, using a cane, walker or wheelchair
- Loss of balance / falls

- Being physically or chemically restrained

With regard to special needs, problems include:

- Medical equipment such as oxygen or tube feeding turned off
- Lack of transportation for outside appointments and trips
- Lack of supplies including soap, toothpaste and denture cleaners

Bladder & Bowel Problems:

Urinary Incontinence. Based on the resident's comprehensive assessment, the facility must ensure that-- (1) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and (2) *A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.* 42 C.F.R. § 483.25(d) (emphasis added).

The nursing home is allowed by law to use a catheter with a resident only if there are medical or clinical conditions that indicate that a catheter is necessary. For any resident who is incontinent, the facility must provide services and treatments to prevent urinary tract infections and to restore as much normal bladder function as possible.

Many times urinary incontinence is temporary and due to medication. Incontinence may be due to the fact that the resident cannot get to the toilet. (Perhaps she is tied to a chair, or her requests for help are not responded to in a timely manner.) The facility is required to look for the causes of the incontinence and implement plans to address those causes. In addition, there should be a bowel and bladder program in place at the facility for those residents who are actually incontinent or at the risk of becoming so.

Problems include:

- Odors
- Wet and soiled clothing
- Lack of assistance getting to the bathroom
- Slow responses to call lights
- Slow responses changing wet or soiled clothes
- No toilet program
- No monitoring of intake and outflow

Loss of Dignity:

A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. 42 C.F.R. § 483.25(a)(3) *See also* 42 C.F.R. § 483.15(a) and § 483.10, *supra*.

The facility must provide assistance to residents who cannot take care of their own activities of daily living. Problems include:

- Dirty, untrimmed nails
- Crusty eyes
- Body odor
- Unkempt hair
- Unshaven
- soiled clothing
- Lack of staff for daily grooming

Boredom & Depression:

Mental and Psychosocial functioning. Based on the comprehensive assessment of a resident, the facility must ensure that-- (1) A resident who displays mental or psychosocial adjustment difficulty, receives appropriate treatment and services to correct the assessed problem, and (2) A resident whose assessment did not reveal a mental or psychosocial adjustment difficulty does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that such a pattern was unavoidable. 42 C.F.R. § 483.25(f).

Problems include:

- Crying
- Withdrawn attitude
- Apathy
- Aggression
- Poor appetite
- Lack of planned activities (especially during nights and weekends)
- Lack of staff interaction with residents

If you have a client who has been harmed by a Tennessee nursing home, it is important to remember that the time for action is short. The statute of limitations is one (1) year. See T.C.A. § 29-26-116.

§ 9.0 Resident's Rights

The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident. 42 C.F.R. § 483.10.

“[N]ursing home staff tend to focus on routine and efficiency. They must care for large numbers of frail, dependent people. Respect for the rights of individual residents sometimes gets lost in the drive to operate efficiently as a business.” *Nursing Homes: Getting Good Care There, supra*, 24.

Numerous articles and websites detail nursing home resident rights. Accordingly, they are not restated here. A good overview of nursing home resident rights can be found in H. Margolis, *The ElderLaw Portfolio Series*, Portfolio 12 (Aspen Law & Publishing 2000).

Sources of Law:

42 U.S.C. § 1396r; 42 C.F.R. § 483.10; T.C.A. § 68-11-901; Tenn. Comp. R. & Regs. 1200-8-6-.12. Another document every Elder Law Attorney should have are the surveyor guidelines, used to interpret the OBRA regulations during the survey process. They are found at <http://www.cms.hhs.gov/manuals/pub07pdf/AP-p-pp.pdf>.

The Grievance/Complaint Process:

In Tennessee, there is no apparent State administered grievance process where a neutral can provide redress for violations of nursing home resident rights. Instead, each facility is required to identify its own internal grievance process and must provide residents with information concerning how it works. Tenn. Comp. R. & Regs. 1200-8-6-.12(w).

If a resident decides to engage a facility's grievance process, she should make her report to:

- The nursing home's administrator, director of nursing, and social worker
- The state or local ombudsman
- The local police or State law enforcement
- A Protection and Advocacy or Adult Protective Services agency
- The state survey agency that licenses and certifies nursing homes (often in the Health Department)
- A citizen advocacy group, or other church or community group that visits regularly.
- Keep trying until you get the assistance you need.

AFTER THE REPORT

- Follow up with the resident and facility to make sure the neglect or abuse has stopped.
- Follow up with the person or agency conducting the investigation. Ask for written copies of findings if allowed by law.
- If the perpetrator is charged with abuse or neglect, the charge will be referred to the state licensing authority. If the guilty person is a nurse aide, the charge will be reported to the state nurse aide registry. This registry is used by nursing homes to prevent abusive aides from working with the elderly. Nursing homes are required to check the registry before hiring a person.
- If all the safety options fail, you may have to contact the local media, the U.S. Justice Department, or seek private legal assistance.

Health Care Facilities Complaint Hotline

877-287-0010

§ 10.0 Involuntary Discharge:

Involuntary Transfer. The movement of a resident between nursing homes, without the consent of the resident, the resident's legal guardian, next of kin or representative. Tenn. Comp. R. & Regs. 1200-8-6-.01(21).

Under the Nursing Home Reform Act, there are only six justifications for an involuntary discharge. They are:

1. transfer or discharge is necessary for the resident's welfare because the resident's needs cannot be met in a nursing facility;
2. transfer or discharge is appropriate because the resident's health has improved to the point that she no longer needs nursing facility services;
3. the resident's presence endangers the safety of individuals in the facility;
4. the resident's presence endangers the health of individuals in the facility;
5. the resident has failed to pay for her nursing facility services; or
6. the nursing home is going out of business.

See 42 C.F.R. § 483.12(a)(2). Tennessee nursing homes must comply with applicable Federal and State regulations. See Tenn. Comp. R. & Regs. 1200-8-6-.05(11)(d).

In Tennessee, Tenn. Comp. R. & Regs. 1200-8-6-.05 imposes the following additional criteria:

(6) No resident shall be discharged without a written order from the attending physician or through other legal processes and timely notification of next of kin and/or sponsor or authorized representative, if any. (7) Each nursing home shall establish a policy for handling patients who wish to leave against medical advice. When a resident is discharged, a brief description of the significant findings and events of the resident's stay in the nursing home, the condition on discharge and the recommendation and arrangement for future care, if any, shall be provided. (8) No resident shall be transferred without a written order from the attending physician or through other legal processes and timely notification of next of kin and/or sponsor or authorized representative, if any. (9) When a resident is transferred, a summary of treatment given at the nursing home, condition of the resident at time of transfer and date and place to which he is transferred shall be entered in the record. If the transfer is due to an emergency, this information will be recorded within forty-eight (48) hours, otherwise, it will precede the transfer of the resident. (10) When a resident is transferred, a copy of the clinical summary shall, with consent of the resident, be sent to the nursing home that will continue the care of the resident.

§ 11.0 Civil Litigation:

A cause of action exists where nursing home resident rights are violated. That subject is not covered here because this paper is focused on improving the quality of care. If you require information concerning potential causes of action, summaries are found in D. McGuffey, *Nursing Home Litigation: A Brief Review of Claims, Preventing Them, Spotting Them, and a Discussion of Discovery Issues* (paper presented at Advanced Elder Law Seminar, March 2003 Atlanta);⁵⁰ Carlson, *Long Term Care Advocacy, supra*, § 10.06; Takacs, *supra*, Chapter 13; L.

⁵⁰ Available from the author.

Frolik & M. Brown, *Advising the Elderly or Disabled Client, Second Edition* § 15.03 (Warren, Gorham & Lamont 1992, 2003); and H. Margolis, *The ElderLaw Portfolio Series*, Portfolio 13 (Aspen Law & Publishing 2000).

In addition, litigants should be aware of the Tennessee medical malpractice statute, which requires the following to prevail in a professional negligence case:

(a) In a malpractice action, the claimant shall have the burden of proving by evidence as provided by subsection (b): (1) The recognized standard of acceptable professional practice in the profession and the specialty thereof, if any, that the defendant practices in the community in which the defendant practices or in a similar community at the time the alleged injury or wrongful action occurred; (2) That the defendant acted with less than or failed to act with ordinary and reasonable care in accordance with such standard; and (3) As a proximate result of the defendant's negligent act or omission, the plaintiff suffered injuries which would not otherwise have occurred.

(b) No person in a health care profession requiring licensure under the laws of this state shall be competent to testify in any court of law to establish the facts required to be established by subsection (a), unless the person was licensed to practice in the state or a contiguous bordering state a profession or specialty which would make the person's expert testimony relevant to the issues in the case and had practiced this profession or specialty in one (1) of these states during the year preceding the date that the alleged injury or wrongful act occurred. This rule shall apply to expert witnesses testifying for the defendant as rebuttal witnesses. The court may waive this subsection when it determines that the appropriate witnesses otherwise would not be available.

(c) In a malpractice action as described in subsection (a), there shall be no presumption of negligence on the part of the defendant; provided, there shall be a rebuttable presumption that the defendant was negligent where it is shown by the proof that the instrumentality causing injury was in the defendant's (or defendants') exclusive control and that the accident or injury was one which ordinarily doesn't occur in the absence of negligence.

(d) In a malpractice action as described in subsection (a), the jury shall be instructed that the claimant has the burden of proving, by a preponderance of the evidence, the negligence of the defendant. The jury shall be further instructed that injury alone does not raise a presumption of the defendant's negligence.

T.C.A. § 29-26-115.

The author of this paper is a member of the Association of Trial Lawyers of America's Nursing Home Litigation Group. Members of the Nursing Home Litigation Group tend to focus their practice on nursing home litigation and may be of assistance if litigation is required.

Conclusion

As Robert Frost said in *Stopping by Woods on a Snowy Evening*, we have promises to keep and miles to go before we sleep. The purpose of this article is to position Elder Law Attorneys so they may participate in the long term care process and make those promises a reality. It will require work, but the destination is worth the price of the journey.

Appendix A

Licensed Facilities

For more information, please contact:
Health Care Facilities: (615)741-7221 or 1-888-310-4650

Current Listings:
Type = Nursing Home County = DAVIDSON

[Click here to return to the search page](#)

<p>1. BELCOURT TERRACE 1710 BELCOURT AVENUE NASHVILLE , TN 37212 (615) 383-3570</p>	<p>Administrator: CYNTHIA R. BRUTON Owner Information: AMERICAN HEALTH FOUNDATION 4248 TULLER ROAD SUITE 201 DUBLIN, OH 43017 (614) 760-7352</p>	<p>Facility License Number: 00000043 Number of Beds: 0049 Date of Last Survey: 09/26/2002 Accreditation Expires: Date of Original Licensure: 07/01/1992 Date of Expiration: 06/30/2004 This Facility is Managed By: AMERICAN HEALTH FOUNDATION SUITE 300 NASHVILLE TN</p>
<p>2. BETHANY HEALTH CARE CENTER 421 OCALA DRIVE NASHVILLE , TN 37211 (615) 834-4214</p>	<p>Administrator: DWIGHT DAVID OSTEEEN Owner Information: AVALON HEALTH CARE, LLC 217 BLANTON AVE NASHVILLE, TN 37210 (615) 255-9670</p>	<p>Facility License Number: 00000044 Number of Beds: 0180 Date of Last Survey: 01/16/2003 Accreditation Expires: Date of Original Licensure: 07/01/1992 Date of Expiration: 06/30/2004 This Facility is Managed By: AVALON HEALTH CARE, LLC NASHVILLE TN</p>
<p>3. CENTENNIAL MEDICAL CENTER - SKILLED NURSING FACILITY 2300 PATTERSON ST. NASHVILLE , TN 37203 (615) 342-3399</p>	<p>Administrator: SUZANNE RUEB Owner Information: HCA HEALTH SERVICES OF TENNESSEE, INC ONE PARK PLAZA NASHVILLE, TN 37202 (615) 344-9551</p>	<p>Facility License Number: 00000046 Number of Beds: 0026 Date of Last Survey: 02/12/2003 Accreditation Expires: 06/28/2004 Date of Original Licensure: 07/01/1992 Date of Expiration: 06/30/2004 This Facility is Managed By: MCKENDREE MANAGEMENT GROUP INC SUITE 213 HERMITAGE TN</p>
<p>4. CORNELIA HOUSE 701 PORTER ROAD NASHVILLE , TN 37206 (615) 226-3264</p>	<p>Administrator: RONALD W. BRIDGES Owner Information: MARK IDE, RECEIVER, RECEIVERSHIP OF EASTLAND INVESTMENT GROUP P.O. BOX 123 SPRING HILL, TN 37174 (615) 308-7831</p>	<p>Facility License Number: 00000050 Number of Beds: 0159 Date of Last Survey: 01/31/2003 Accreditation Expires: Date of Original Licensure: 07/01/1992 Date of Expiration: 06/30/2004 This Facility is Managed By: MARK IDE MANAGEMENT GROUP, INC. SPRING HILL TN</p>
<p>5. CRESTVIEW NURSING HOME 2030 25TH AVENUE NORTH NASHVILLE , TN 37208-1369 (615) 256-4697</p>	<p>Administrator: DAHLEN JORDAN Owner Information: VANGUARD OF CRESTVIEW LLC TWO INTERNATIONAL PLAZA DRIVE SUITE 200 NASHVILLE, TN 37217 (615) 367-0770</p>	<p>Facility License Number: 00000047 Number of Beds: 0111 Date of Last Survey: 03/12/2003 Accreditation Expires: Date of Original Licensure: 07/01/1992 Date of Expiration: 06/30/2004 This Facility is Managed By: NASHVILLE MANAGEMENT ASSOCIATES, LLC</p>

		SUITE 310 BRENTWOOD TN
6. CUMBERLAND MANOR 4343 HYDES FERRY PIKE NASHVILLE , TN 37218-2401 (615) 726-0492	Administrator: ROBERT VENABLE Owner Information: CUMBERLAND MANOR INC. 4343 HYDES FERRY PIKE NASHVILLE, TN 37218 (615) 726-0492	Facility License Number: 00000048 Number of Beds: 0124 Date of Last Survey: 10/14/2002 Accreditation Expires: Date of Original Licensure: 07/01/1992 Date of Expiration: 06/30/2004 This Facility is Managed By: TENNESSEE HEALTH MANAGEMENT, INC. PARSONS TN
7. GOOD SAMARITAN HEALTH AND REHAB CENTER 500 HICKORY HOLLOW TERRACE ANTIOCH , TN 37013 (615) 731-7130	Administrator: JOHN M. PUGH Owner Information: EBENZER HOME OF TENNESSEE 500 HICKORY HOLLOW TERRACE ANTIOCH, TN 37013 (615) 731-7130	Facility License Number: 00000051 Number of Beds: 0115 Date of Last Survey: 10/31/2002 Accreditation Expires: Date of Original Licensure: 07/01/1992 Date of Expiration: 06/30/2004
8. HQM OF NASHVILLE 2733 MCCAMPBELL AVE. NASHVILLE , TN 37214-2913 (615) 885-0483	Administrator: SAM W. SULLIVAN Owner Information: HQM OF NASHVILLE, LLC 2401 PGA BLVD. SUITE 155 PALM BEACH GARDENS, FL 33410 (561) 627-0664	Facility License Number: 00000049 Number of Beds: 0124 Date of Last Survey: 10/16/2002 Accreditation Expires: Date of Original Licensure: 07/01/1992 Date of Expiration: 06/30/2004 This Facility is Managed By: HOME QUALITY MANAGEMENT, INC. SUITE 155 PALM BEACH GARDENS FL
9. IMPERIAL MANOR CONVALESCENT CENTER 306 W. DUE WEST AVENUE MADISON , TN 37115 (615) 865-5001	Administrator: MARTIN HILL, ACTING Owner Information: IMPERIAL MANOR CONVALESCENT CENTER LLC 306 WEST DUE WEST AVENUE MADISON, TN 37115 (615) 865-5001	Facility License Number: 00000053 Number of Beds: 0165 Date of Last Survey: 12/12/2002 Accreditation Expires: Date of Original Licensure: 07/01/1992 Date of Expiration: 06/30/2004 This Facility is Managed By: MADISON MANAGEMENT ASSOCIATES, LLC SUITE 310 BRENTWOOD TN
10. JACKSON PARK CHRISTIAN HOME, INC. 4107 GALLATIN ROAD NASHVILLE , TN 37216 (615) 228-0356	Administrator: PATRICIA GAMMEL Owner Information: JACKSON PARK CHRISTIAN HOME, INC 4107 GALLATIN ROAD NASHVILLE, TN 37216 (615) 228-0356	Facility License Number: 00000055 Number of Beds: 0028 Date of Last Survey: 03/06/2003 Accreditation Expires: Date of Original Licensure: 07/01/1992 Date of Expiration: 06/30/2004
11. LAKESHORE ESTATES 832 WEDGEWOOD AVENUE NASHVILLE , TN 37203 (615) 383-4006	Administrator: DEBBIE HANKINS Owner Information: LAKESHORE ESTATES, CHAIRMAN 832 WEDGEWOOD AVENUE NASHVILLE, TN 37203 (615) 383-4006	Facility License Number: 00000057 Number of Beds: 0061 Date of Last Survey: 02/20/2003 Accreditation Expires: Date of Original Licensure: 07/01/1992 Date of Expiration: 06/30/2004
12. LAKESHORE HEARTLAND 3025 FERNBROOK LANE NASHVILLE , TN 37214-1601 (615) 885-2320	Administrator: KEN RAGLAND Owner Information: LAKESHORE ESTATES, INC. 8044 COLEY DAVIS ROAD NASHVILLE, TN 37221 (615) 646-4466	Facility License Number: 00000056 Number of Beds: 0066 Date of Last Survey: 12/04/2002 Accreditation Expires: Date of Original Licensure: 07/01/1992 Date of Expiration: 06/30/2004
13. MADISON HEALTHCARE AND REHABILITATION CENTER 431 LARKIN SPRINGS RD MADISON , TN 37115 (615) 865-8520	Administrator: MELISSA HANSEN Owner Information: KINDRED HEALTHCARE, INC LIMITED PARTNERSHIP; 3300 AEGON CENTER; 400 WEST MARKET ST. LOISVILLE, KY 40202	Facility License Number: 00000054 Number of Beds: 0102 Date of Last Survey: 12/11/2003 Accreditation Expires: Date of Original Licensure: 07/01/1992 Date of Expiration: 06/30/2004

	(502) 596-7300	
14. MARINER HEALTH OF NASHVILLE 3939 HILLSBORO CIRCLE NASHVILLE , TN 37215-2708 (615) 297-2100	Administrator: MOLLY MITCHELL Owner Information: PINNACLE CARE CORPORATION OF NASHVILLE 3939 HILLSBORO CIRCLE NASHVILLE, TN 37215 (615) 297-2100	Facility License Number: 00000052 Number of Beds: 0150 Date of Last Survey: 11/07/2002 Accreditation Expires: 06/27/2001 Date of Original Licensure: 07/01/1992 Date of Expiration: 06/30/2004 This Facility is Managed By: MARINER HEALTH CARE MANAGEMENT COMPANY SUITE 1500 ATLANTA GA
15. MCKENDREE VILLAGE, INC. 4347 LEBANON ROAD HERMITAGE , TN 37076 (615) 871-8780	Administrator: HAROLD ERMSHAR Owner Information: MCKENDREE VILLAGE INC 4347 LEBANON ROAD HERMITAGE, TN 37076 (615) 871-8232	Facility License Number: 00000058 Number of Beds: 0300 Date of Last Survey: 09/13/2002 Accreditation Expires: 11/14/2000 Date of Original Licensure: 07/01/1992 Date of Expiration: 06/30/2004
16. NASHVILLE METROPOLITAN BORDEAUX HOSPITAL/NURSING FACILITY 1414 COUNTY HOSPITAL ROAD NASHVILLE , TN 37218 (615) 862-7005	Administrator: MAY BENNETT Owner Information: METROPOLITAN GOVERNMENT OF NASHVILLE & DAVIDSON COUNTY TN () -	Facility License Number: 00000063 Number of Beds: 0420 Date of Last Survey: 03/01/2002 Accreditation Expires: Date of Original Licensure: 07/01/1992 Date of Expiration: 06/30/2004
17. NHC HEALTHCARE, NASHVILLE 2215 PATTERSON ST. NASHVILLE , TN 37203 (615) 327-3011	Administrator: MARY ELLEN MAYFIELD Owner Information: NHC HEALTHCARE NASHVILLE LLC 2215 PATTERSON STREET NASHVILLE, TN 37203 (615) 327-3011	Facility License Number: 00000061 Number of Beds: 0124 Date of Last Survey: 03/15/2002 Accreditation Expires: 06/26/2002 Date of Original Licensure: 07/01/1992 Date of Expiration: 06/30/2004
18. RIVER PARK HEALTH CARE 1306 KATIE AVENUE NASHVILLE , TN 37207 (615) 228-3494	Administrator: JOE GARAFOLA Owner Information: RIVER PARK HEALTH CARE, LLC 1306 KATIE AVENUE NASHVILLE, TN 37207 (615) 228-3494	Facility License Number: 00000062 Number of Beds: 0058 Date of Last Survey: 09/19/2002 Accreditation Expires: Date of Original Licensure: 07/01/1992 Date of Expiration: 06/30/2004
19. SKYLINE MEDICAL CENTER TRANSITIONAL CARE UNIT 3441 DICKERSON PIKE NASHVILLE , TN 37207 (615) 769-7300	Administrator: MARK SIMS (INTERIM) Owner Information: HTI MEMORIAL HOSPITAL CORP ONE PARK PLAZA NASHVILLE, TN 37203 (615) 344-9551	Facility License Number: 00000307 Number of Beds: 0008 Date of Last Survey: 11/13/2001 Accreditation Expires: 06/12/2004 Date of Original Licensure: 07/01/1992 Date of Expiration: 06/30/2004
20. THE HEALTH CENTER AT RICHLAND PLACE 504 ELMINGTON AVENUE NASHVILLE , TN 37205-2508 (615) 292-4900	Administrator: Timothy J. Shelly Owner Information: RICHLAND PLACE INC 504 ELMINGTON AVENUE NASHVILLE, TN 37205 (615) 292-4900	Facility License Number: 00000309 Number of Beds: 0107 Date of Last Survey: 11/06/2002 Accreditation Expires: Date of Original Licensure: 07/01/1992 Date of Expiration: 06/30/2004 This Facility is Managed By: NATIONAL HEALTHCARE CORPORATION MURFREESBORO TN
21. THE MEADOWS 8044 COLEY DAVIS RD. NASHVILLE , TN 37221 (615) 646-4466	Administrator: ELIZABETH G. OLDHAM Owner Information: LAKE SHORE ESTATES, INC. 8044 COLEY DAVIS ROAD NASHVILLE, TN 37221-2310 (615) 646-4466	Facility License Number: 00000059 Number of Beds: 0113 Date of Last Survey: 04/29/2003 Accreditation Expires: Date of Original Licensure: 07/01/1992 Date of Expiration: 06/30/2004

22. THE WINDSOR HOUSE 3425 KNIGHT DRIVE WHITES CREEK , TN 37189 (615) 876-2754	Administrator: DEBORAH BEASLEY Owner Information: OP WHITES CREEK, INC. 200 CORPORATE CENTER DRIVE # 360 MOONTOWNSHIP, PA 15108 (412) 269-2400	Facility License Number: 00000069 Number of Beds: 0127 Date of Last Survey: 05/22/2003 Accreditation Expires: Date of Original Licensure: 07/01/1992 Date of Expiration: 06/30/2004
23. TREVCCA HEALTH CARE CENTER 329 MURFREESBORO ROAD NASHVILLE , TN 37210 (615) 244-6900	Administrator: SHARON GOFF Owner Information: AVALON HEALTH CARE LLC 217 BLANTON AVE. NASHVILLE, TN 37210 () -	Facility License Number: 00000066 Number of Beds: 0240 Date of Last Survey: 03/05/2003 Accreditation Expires: Date of Original Licensure: 07/01/1992 Date of Expiration: 06/30/2004 This Facility is Managed By: MANAGEMENT CORP. OF AMERICA NASHVILLE TN
24. VANCO MANOR NURSING CENTER 813 SOUTH DICKERSON ROAD GOODLETTSVILLE , TN 37072-1707 (615) 859-6600	Administrator: SOHEILA KHESHTI Owner Information: RIVERGATE MANOR, INC P.O. BOX 10 PARSONS, TN 38363 (731) 847-6343	Facility License Number: 00000067 Number of Beds: 0066 Date of Last Survey: 07/31/2002 Accreditation Expires: Date of Original Licensure: 07/01/1992 Date of Expiration: 06/30/2004 This Facility is Managed By: TENNESSEE HEALTH MANAGEMENT, INC. PARSONS TN
25. VANDERBILT UNIVERSITY HOSPITAL/SKILLED NURSING FACILITY HOSPITAL ADMINISTRATION, ROOM AA1204 MCN 1161 21ST AVE SOUTH 57400 MCN NASHVILLE , TN 37232-2102 (615) 322-5302	Administrator: VICKIE W. HARRIS Owner Information: VANDERBILT UNIVERSITY MEDICAL CENTER 1211 22ND AVENUE SOUTH NASHVILLE, TN 37232 (615) 343-5000	Facility License Number: 00000335 Number of Beds: 0027 Date of Last Survey: 12/30/2002 Accreditation Expires: 06/24/2003 Date of Original Licensure: 03/30/1995 Date of Expiration: 06/30/2004
26. WEST END HEALTH CARE CENTER 2818 VANDERBILT PLACE NASHVILLE , TN 37212-2522 (615) 327-4208	Administrator: HOWARD RANDALL CORNWELL Owner Information: WEST END BOARD OF DIRECTORS 2818 VANDERBILT PLACE NASHVILLE, TN 37212 (615) 327-3875	Facility License Number: 00000068 Number of Beds: 0013 Date of Last Survey: 03/20/2003 Accreditation Expires: Date of Original Licensure: 07/01/1992 Date of Expiration: 06/30/2004
27. WEST MEADE PLACE 1000 ST. LUKE DRIVE NASHVILLE , TN 37205 (615) 352-3430	Administrator: JAMES L. WRIGHT Owner Information: WEST MEADE PLACE L.P. 100 CHOPIN PLACE 1500 EDWARD BALL BUILDING MIAMI, FL 33133 (305) 379-9104	Facility License Number: 00000045 Number of Beds: 0120 Date of Last Survey: 03/22/2002 Accreditation Expires: Date of Original Licensure: 07/01/1992 Date of Expiration: 06/30/2004 This Facility is Managed By: WEST MEADE MANAGEMENT, INC. MIAMI FL
28. WOODCREST AT BLAKEFORD 11 BURTON HILLS BOULEVARD NASHVILLE , TN 37215-6138 (615) 665-2524	Administrator: LOIS JOHNSTONE Owner Information: THE BLAKEFORD AT GREENHILLS CORP 11 BURTON HILLS BLVD NASHVILLE, TN 37215 (615) 665-9505	Facility License Number: 00000343 Number of Beds: 0040 Date of Last Survey: 03/05/2003 Accreditation Expires: Date of Original Licensure: 05/28/1996 Date of Expiration: 06/30/2004

Appendix B

Tennessee Local Ombudsman Offices

Toll-free State Wide Long-Term Care Information : 1-866-836-6678

1	Vickie Snodgrass Long-Term Care Ombudsman Legal Aid of East TN 311 West Walnut St. PO Drawer 360 Johnson City, TN 37605-0360 Phone: 423 928.8311 x27 Fax: 423 928.9488	Web Site: www.long-termcareombudsman.org
2	Howard Hinds Long-Term Care Ombudsman East TN Human Resource Agency 9111 Cross Park Drive Suite D-100 Knoxville, TN 37923-4517 865-691-2551 fax 531-7216	Web Site: http://www.ethra.org/html/index.htm
3	Trudy Mott Long-Term Care Ombudsman Partnership for Families, Children and Adults 225 East Eighth St. PO Box 11398 Chattanooga, TN 37401-2398 423-755-2877 fax 755-2755	
4	Nancy Hendricks Long-Term Care Ombudsman Aging Services for the UpperCumberlands 1225 South Willow Avenue Cookeville, TN 38506-4194 931-432-4210 fax 432-6010	
5	Jean M. (Sue) Chascsa Prince Long-Term Care Ombudsman Mid-Cumberland Human Resource Agency 301 South Perimeter Park Drive Suite 210 (37211-4128) PO Box 111419 Nashville, TN 37222-1419 615-850-3922 fax 833-2585	Web Site: http://www.MCHRA.COM

6	<p>Cheryl Lynne Vallance Long-term Care Ombudsman South Central TN Human Resource Agency 606 Lee Avenue (37334-2428)PO Box 638 Fayetteville, TN 37334-0638 931-433-7182 ext 103 fax 931-438-0074</p>	
7	<p>Marchell Gardner Long-Term Care Ombudsman Northwest Dev. District 124 Weldon Drive (38237-1308) PO Box 963 Martin, TN 38237-0963 731-587-4213 fax 588-0441</p>	
8	<p>Amanda Scott Long-Term Care Ombudsman Senior Citizens Law Project 27A Brentshire Square (38305-2214) PO Box 2066 Jackson, TN 38302-2066 731-512-4112 fax 668-7296</p>	<p>Web Site: http://www.wtlls.org</p>
9	<p>Sandra Smegelsky Long-Term Care Ombudsman Metropolitan Inter-Faith Assoc. 910 Vance Avenue (38126-2911) PO Box 3130 Memphis, TN 38173-0130 901-527-0208 fax 523</p>	

Appendix C

Nursing Home Checklist

Nursing Home Name: _____

Date Visited: _____

Address: _____

Basic Information

1. Is the facility Medicare certified?: _____(yes) _____(no)
2. Is the facility Medicaid certified?: _____(yes) _____(no)
3. Is this a skilled nursing facility?: _____(yes) _____(no)
4. Is the facility accepting new patients?: _____(yes) _____(no)
5. Is there a waiting period for admission?: _____(yes) _____(no)
6. Is a skilled bed available to you?: _____(yes) _____(no)

Useful Tips

Generally, skilled nursing care is available only for a short period of time after a hospitalization. Custodial care is for a much longer period of time. If a facility offers both types of care, ask if residents may transfer between levels of care within the nursing home without having to move from their old room or from the nursing home. Nursing homes that only take Medicaid residents might offer longer term but less intensive levels of care. Nursing Homes that don't accept Medicaid payment may make a resident move when Medicare or the resident's own money runs out. An occupancy rate is the total number of residents currently living in a nursing home divided by the home's total number of beds. Occupancy rates vary by area, depending on the overall number of available nursing home beds.

Nursing Home Information

- Is the home and the current administrator licensed?: _____(yes) _____(no)
- Does the home conduct background checks on all staff?: _____(yes) _____(no)
- Does the home have special services units?: _____(yes) _____(no)
- Does the home have abuse prevention training?: _____(yes) _____(no)

Useful Tips

LICENSURE: The nursing home and its administrator should be licensed by the State to operate.

BACKGROUND CHECKS: Do the nursing home's procedures to screen potential employees for a history of abuse meet your State's requirements? Your State's Ombudsman program might be able to help you with this information.

SPECIAL SERVICES: Some nursing homes have special service units like rehabilitation, Alzheimer's, and hospice. Learn if there are separate waiting periods or facility guidelines for when residents would be moved on or off the special unit.

STAFF TRAINING: Do the nursing home's training programs educate employees about how to recognize resident abuse and neglect, how to deal with aggressive or difficult residents, and how to deal with the stress of caring for so many needs? Are there clear procedures to identify events or trends that might lead to abuse and neglect, and on how to investigate, report, and resolve your complaints?

LOSS PREVENTION: Are there policies or procedures to safeguard resident possessions? For Sections III through VI, give the nursing home a grade from one to five. One is worst, five is best.

Quality of Life:	Worst				Best
1. Residents can make choices about their daily routine. Examples are when to go to bed or get up, when to bathe, or when to eat.	1	2	3	4	5
2. The interaction between staff and patient is warm and respectful.	1	2	3	4	5
3. The home is easy to visit for friends and family.	1	2	3	4	5
4. The nursing home meets your cultural, religious, or language needs.	1	2	3	4	5
5. The nursing home smells and looks clean and has good lighting.	1	2	3	4	5
6. The home maintains comfortable temperatures.	1	2	3	4	5
7. The resident rooms have personal articles and furniture.	1	2	3	4	5
8. The public and resident rooms have comfortable furniture.	1	2	3	4	5
9. The nursing home and its dining room are generally quiet.	1	2	3	4	5
10. Residents may choose from a variety of activities that they like.	1	2	3	4	5
11. The nursing home has outside volunteer groups.	1	2	3	4	5
12. The nursing home has outdoor areas for resident use and helps residents to get outside.	1	2	3	4	5

TOTAL: _____
 (Best Possible Score: 60)

Quality of Care:	Worst				Best
1. The facility corrected any Quality of Care deficiencies that were in the State inspection report.	1	2	3	4	5
2. Residents may continue to see their personal physician.	1	2	3	4	5
3. Residents are clean, appropriately dressed, and well groomed.	1	2	3	4	5
4. Nursing Home staff respond quickly to requests for help.	1	2	3	4	5
5. The administrator and staff seem comfortable with each other and with the residents.	1	2	3	4	5
6. Residents have the same care givers on a daily basis.	1	2	3	4	5
7. There are enough staff at night and on week-ends or holidays to care for each resident.	1	2	3	4	5
8. The home has an arrangement for emergency situations with a nearby hospital.	1	2	3	4	5
9. The family and residents councils are independent from the nursing home's management.	1	2	3	4	5
10. Care plan meetings are held at times that are easy for residents and their family members to attend.	1	2	3	4	5

TOTAL: _____
 (Best Possible Score: 50)

Useful Tips

Good care plans are essential to good care. They should be put together by a team of providers and family and updated as often as necessary.

Nutrition and Hydration (Diet and Fluids):	Worst				Best
1. The home corrected any deficiencies in these areas that were on the recent state inspection report.	1	2	3	4	5

2. There are enough staff to assist each resident who requires help with eating.	1	2	3	4	5
3. The food smells and looks good and is served at proper temperatures.	1	2	3	4	5
4. Residents are offered choices of food at mealtimes.	1	2	3	4	5
5. Residents' weight is routinely monitored.	1	2	3	4	5
6. There are water pitchers and glasses on tables in the rooms.	1	2	3	4	5
7. Staff help residents drink if they are not able to do so on their own.	1	2	3	4	5
8. Nutritious snacks are available during the day and evening.	1	2	3	4	5
9. The environment in the dining room encourages residents to relax, socialize, and enjoy their food.	1	2	3	4	5

TOTAL: _____
 (Best Possible Score: 45)

Useful Tips

Ask the professional staff how the medicine a resident takes can affect what they eat and how often they may want something to drink.

Visit at mealtime. Are residents rushed through meals or do they have time to finish eating and to use the meal as an opportunity to socialize with each other?

Sometimes the food a home serves is fine, but a resident still won't eat. Nursing home residents may like some control over their diet. Can they select their meals from a menu or select their mealtime?

If residents need help eating, do care plans specify what type of assistance they will receive?

Safety	Worst				Best
1. There are handrails in the hallways and grab bars in the bathrooms.	1	2	3	4	5
2. Exits are clearly marked.	1	2	3	4	5
3. Spills and other accidents are cleaned up quickly.	1	2	3	4	5
4. Hallways are free of clutter and have good lighting.	1	2	3	4	5
5. There are enough staff to help move	1	2	3	4	5

residents quickly in an emergency.					
6. The nursing home has smoke detectors and sprinklers.	1	2	3	4	5

TOTAL: _____
 (Best Possible Score: 30)

Useful Tips Relating to Information in Nursing Home Compare

Nursing Home Compare contains summary information about nursing homes from their last state inspection. It also contains information that was reported by the nursing homes prior to the last State inspection including nursing home and resident characteristics. If you have questions or concerns about the information on a nursing home, you should discuss them during your visit.

This section contains useful tips and questions that you may want to ask the nursing home staff, family members and residents of the nursing home during your visit.

1. Bring a copy of the Nursing Home Compare inspection results for the nursing home. Ask whether the deficiencies have been corrected.
2. Ask to see a copy of the most recent nursing home inspection report.
3. Does it appear that there is sufficient staff to assist residents who need help in moving or getting in and out of chairs and bed?
4. Ask the Director of Nursing who is involved in the decisions about physical restraints.
5. When physical restraints are used, do the staff remove the physical restraints on a regular basis to help residents with moving, and with activities of daily living?
6. Do the staff help residents with physical restraints to get in and out of bed and chairs when they want to get up?
7. Do staff help residents with physical restraints to move as much as they would like to?
8. Ask the staff how they identify if a resident is at risk for skin breakdown. Ask them what they do to prevent pressure sores for these residents.
9. Ask the staff about the percentage of their residents that have pressure sores and why.
10. Do you see staff helping residents change their positions in wheelchairs, chairs, and beds?

11. Does the nursing home smell clean?
12. Ask the staff what steps they take to prevent bowel and bladder incontinence for residents who are at risk.
13. Observe residents who need help in eating. Are they able to finish their meals or is the food returned to the kitchen uneaten?
14. Ask the Director of Nursing how staff are assigned to care for these residents.
15. Ask the Director of Nursing how the nursing home cares for residents with restricted joint motion.
16. Do the residents get help with getting out of chairs and beds when they want to get up?
17. What management and/or medical approaches for behavioral symptoms are being used by the nursing home?
18. How does staff handle residents that have behavioral symptoms such as calling out or yelling?
19. Ask whether residents with behavioral symptoms are checked by a doctor or behavioral specialist.
20. Ask whether staff get special training to help them to provide care to residents with behavioral symptoms.
21. Caring, competent nursing staff who respect each resident and family member are very important in assuring that residents get needed care and enjoy the best possible quality of life. Adequate nursing staff is needed to assess resident needs, plan and give them care, and help them with eating, bathing and other activities. Some residents (e.g., those who are more dependent in eating or who are bedfast) need more help than other residents depending on their conditions. The combinations of registered nurses (RNs), licensed practical and vocational nurses (LPNs/LVNs), and certified nursing assistants (CNAs) that nursing homes may have vary depending on the type of care that residents need and the number of residents in the nursing home.
22. Are nursing staff members courteous and friendly to residents and to other staff?
23. Do nursing staff respond timely to resident's calls for assistance such as help getting in and out of bed, dressing and going to the bathroom?
24. Observe meal times. Do all residents who need assistance with eating get help? Does staff give each resident enough time to chew food thoroughly and complete the meal?

25. Which nursing staff members are involved in planning the resident's individual care?
(Are they the same ones who give the care to residents?)
26. Ask questions about staff turnover. Is there frequent turnover among certified nursing assistants (CNAs)? What about nurses and supervisors, including the Director of Nursing and the Administrator? If staff changes frequently, ask why.
27. While the number of nursing staff is important to good care, also consider other factors, such as education and training. How many registered nurses (RNs) are on the staff, and how many available on each shift? What kind of training do certified nursing assistants (CNAs) receive?
28. How does the nursing home ensure that all staff receives continuing education and keeps their knowledge and skills up-to-date?
29. Ask about the facility's fire safety and emergency evacuation plan.

Appendix D

Nursing Home Statutes & Regulations⁵¹

States	NH Statutes	NH Regulations
Alabama	Ala.Code 1975 § 34-20-1 et seq. (administrators)	Ala. Admin Code 420-5-10
Alaska	AS 08.70.080 et seq. (Administrators); AS 18.20.010 (Hospitals and nursing facilities); AS 18.20.300 (nursing facilities)	Alaska Admin Code tit. 7, § 12.258 to 12.290
Arizona	A.R.S. Sections 46-451 – 456	Ariz. Admin. Code 9-10-901 et seq.
Arkansas	A.C.A. § 20-10-1401 et seq. (staffing)	
California	Health & Safety Code section 1250, et seq.; 1417, et seq.	22 Cal. Code Regs 72001, et seq.
Colorado	C.R.S.A. § 12-39-101 (administrators)	
Connecticut	Title 19A, Chapter 368V	
Delaware		
Florida	FS 400.011--400.332	FAC 59A-4
Georgia	O.C.G.A. § 31-8-100 et seq.	GAC § 290-5-39-.01 et seq.
Hawaii		
Idaho	Idaho Code 67-5001 et seq. (Commission on Aging); Idaho Code 39-3501 et seq. (Residential Care for the Elderly); Idaho Code 39-5301 et seq. (Adult Abuse, Neglect and Exploitation Act); Idaho Code 54-1601 et seq. (Nursing Home Administrators); and Idaho Code 6-2301 et seq. (Claims Against Nursing Home Facilities).	Idaho Administrative Code 16.03.02.000 et seq
Illinois	210 ILCS 45/1-101 et seq	77 Ill. Adm. Code 300
Indiana	I.C. 16-28, et seq	410 I.A.C. 16.2 - 3.1, et seq
Iowa		
Kansas	K.S.A. 39-923, et seq	K.A.R. 28-39-144, et seq.; Interpretive Guideline Number 93-1 et.seq
Kentucky	KRS § 216.510 et seq. See generally, Chapters 216, 216A and 216B	KAR Titles 900, 901, 906, 907 and 910
Louisiana		
Maine		
Maryland	19-1801 to 1806 (ass't living); 19-1901 to 1912 (adult care care); 19-343 to 19-352 (nursing homes)	COMR 10.07.14 (assisted living) COMR 10.07.09 (nursing homes)
Massachusetts		105 CMR 150.000 - 159.000

⁵¹ The author gratefully acknowledges the assistance of members of ATLA’s Nursing Home Litigation Group in compiling the information presented in this chart.

		940 CMR 4.00 – 4.11 245 CMR 1.00 – 2.18
Michigan		
Minnesota		
Mississippi	MS Code § 43-11-1, et seq	Minimum Standards for Institutions for the Aged or Infirm § 101.1, et seq.
Missouri	RSMo. 198.003 - 198.186	
Montana		
Nebraska		
Nevada		
New Hampshire		
New Jersey	NJSA26:2H- et seq.	NJAC (administrative code) Title 8, Chapt. 43 E; 42C (hospice); 43H (rehabilitation hosp.); Title 10, ch. 35 (county psych facilities).
New Mexico	7.9.2 NMAC, § 7.9.2.1-7.9.2.88, et seq	
New York	Public Health Law (PHL) 2801-d	10 NYCRR 415.12
North Carolina	N.C.G.S. 131E-100 through -134	10 NCAC subchapter 3H
North Dakota		
Ohio	Ohio Revised Code Chapter 3721	Ohio Administrative Code Chapters 3701-17, 18, 20, and 61
Oklahoma	63 O.S. § 1-1901 et seq	OAC 310:675-1-1 et seq.
Oregon		
Pennsylvania	Health Care Facilities Act, 35 P.S. Sect. 448.101 et seq.	28 Pa.Code Sub-part C, Chapters 201 et seq. (Long-term Care Facilities)
Rhode Island	Chapter 23-17	
South Carolina		Code of Regs. 61-17
South Dakota		
Tennessee	T.C.A. § 68-11-901 (rights); § 68-11-803 (Type B violations); § 68-11-804 (Type C violations)	TCRR § 1200-8-6-.01 et seq.
Texas		40 TAC sec. 18.1 et seq 40 TAC sec. 19.1 et seq 40 TAC sec. 19.401 et seq.
Utah		
Vermont		
Virginia		
Washington		
West Virginia	W. Va. Code 16-5C-1 et seq. (NH) 30-25-1 (Administrators); 16-5L-1 (Ombudsmen); 55-7B-1 (Medical Professional Liability Act)	64 CSR 13 Nursing Home Licensure Rule; 21 CSR 1 Nursing Home Administrators Lic. Bd.; 12 CSR 1 Licensing Advisory Council Proc.

		Rules
Wisconsin		
Wyoming		

Appendix E

TENNESSEE RULES AND REGULATIONS
1200. THE TENNESSEE DEPARTMENT OF HEALTH, ENVIRONMENT AND
CONSERVATION,
FINANCE AND ADMINISTRATION
1200-8. BOARD FOR LICENSING HEALTH CARE FACILITIES
CHAPTER 1200-8-6. STANDARDS FOR NURSING HOMES
Current through October 1, 2003

1200-8-6-.12. RESIDENT RIGHTS.

(1) The nursing home shall establish and implement written policies and procedures setting forth the rights of residents for the protection and preservation of dignity, individuality and, to the extent medically feasible, independence. Residents and their families or other representatives shall be fully informed and documentation shall be maintained in the resident's file of the following rights:

- (a) To privacy in treatment and personal care;
- (b) To privacy, if married, for visits by his/her spouse;
- (c) To share a room with his/her spouse (if both are residents);
- (d) To be different, in order to promote social, religious and psychological well being;
- (e) To privately talk and/or meet with and see anyone;
- (f) To send and receive mail promptly and unopened;
- (g) To be free from mental and physical abuse. Should this right be violated, the facility must notify the department within five (5) working days. The Tennessee Department of Human Services, Adult Protective Services shall be notified immediately as required in T.C.A. § 71-6-103;
- (h) To be free from chemical and physical restraints;
- (i) To meet with members of and take part in activities of social, commercial, religious and community groups. The administrator may refuse access to the facility to any person if that person's presence would be injurious to the health and safety of a resident or staff, or would threaten the security of the property of the resident, staff or facility;

(j) To form and attend resident council meetings. The facility shall provide space for meetings and reasonable assistance to the council when requested;

(k) To retain and use personal clothing and possessions as space permits;

(l) To be free from being required by the facility to work or perform services;

(m) To be fully informed by a physician of his/her health and medical condition. The facility shall give the resident and family the opportunity to participate in planning the resident's care and medical treatment;

(n) To refuse treatment. The resident must be informed of the consequences of that decision. The refusal and its reason must be reported to the physician and documented in the medical record;

(o) To refuse experimental treatment and drugs. The resident's written consent for participation in research must be obtained and retained in the medical record;

(p) To have records kept confidential and private. Written consent by the resident must be obtained prior to release of information except to persons authorized by law. If the resident is mentally incompetent, written consent is required from the resident's legal representative. The nursing home must have policies to govern access and duplication of the resident's record;

(q) To manage personal financial affairs. Any request by the resident for assistance must be in writing. A request for any additional person to have access to a resident's funds must also be in writing;

(r) To be told in writing before or at the time of admission about the services available in the facility and about any extra charges, charges for services not covered under Medicare or Medicaid, or not included in the facility's bill;

(s) To be free from discrimination because of the exercise of the right to speak and voice complaints;

(t) To exercise his/her own independent judgment by executing any documents, including admission forms;

(u) To have a free choice of providers of medical services, such as physician and pharmacy. However, medications must be supplied in packaging consistent with the medication system of the nursing home;

(v) To be free from involuntary transfer or discharge, except for these reasons:

1. Medical reasons;

2. His/her welfare or that of the other residents; or

3. Nonpayment, except as prohibited by the Medicaid program;

(w) To voice grievances and complaints, and to recommend changes in policies and services to the facility staff or outside representatives of the resident's choice. The facility shall establish a grievance procedure and fully inform all residents and family members or other representatives of the procedure;

(x) To have appropriate assessment and management of pain; and

(y) To be involved in the decision making of all aspects of their care.

(2) The rights set forth in this section may be abridged, restricted, limited or amended only as follows:

(a) When medically contraindicated;

(b) When necessary to protect and preserve the rights of other residents in the facility; or

(c) When contradicted by the explicit provisions of another rule of the board.

(3) Any reduction in residents' rights based upon medical consideration or the rights of other residents must be explicit, reasonable, appropriate to the justification, and the least restrictive response feasible. They may be time- limited, shall be explained to the resident, and must be documented in the individual resident's record by reciting the limitation's reason and scope. Medical contraindications shall be supported by a physician's order. At least once each month, the administrator and the director of nursing shall review the restriction's justification and scope before removing it, amending it, or renewing it. The names of any residents in the facility whose rights have been restricted under the provisions of this rule shall be maintained on a separate list which shall be available for inspection by the department and by the area long-term care ombudsman.

Authority: T.C.A. § § 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68- 11-206, 68-11-209, 68-11-901, and 68-11-902. Administrative History: Original rule filed March 27, 1975; effective April 25, 1975. Repeal and new rule filed July 14, 1983; effective August 15, 1983. Amendment filed May 24, 1985; effective June 23, 1985. Amendment filed March 13, 1986; effective April 12, 1986. Amendment filed October 22, 1987; effective December 6, 1987. Amendment filed May 10, 1990; effective June 24, 1990. Amendment filed March 9, 1992; effective April 23, 1992. Amendment filed March 10, 1995; effective May 24, 1995. Amendment filed June 13, 1997; effective August 27, 1997. Repeal and new rule filed January 26, 2000; effective April 20, 2000. Amendment filed June 18, 2002; effective September 1, 2002.

Appendix F

Form of Grievance

This form may be used as a guide when filing a nursing home abuse complaint.⁵²

Date: _____

Name (person completing form): _____

Address: _____

Address: _____

City _____ State _____ Zip _____

Daytime phone number _____

Evening phone number _____

Name of facility _____

Address of facility _____

City _____ State _____ Zip _____

Name of resident on whose behalf the complaint is made:

Complaint:

Date(s) of incident:

Shift(s) when incident(s) occurred: Day/Afternoon/Night

Time(s):

Shift(s) when incident(s) occurred, if known:

Day Afternoon Night Time(s): _____

Witnesses to Event:

Records to be examined:

Name of staff person(s) involved:

cc: Local Ombudsman

⁵² Residents may voice grievances to the nursing home or to third parties, such as the Ombudsman or State regulators. (or both) If a grievance is filed with the nursing home, “a resident has a right to ... prompt efforts, by the facility to have grievances resolved.” 42 C.F.R. 483.10(f).