Overview
In exchange for Medicare and Medi-Cal payments, certified nursing homes agree to give each resident the best possible care. Specifically, the federal Nursing Home Reform Act of 1987 requires them to help each resident attain or maintain the highest practicable physical, mental and psychosocial well-being. 42 USC §1396r(b)(2). Care, treatment and therapies must be used to maintain and improve health to the extent possible (42 USC §1396r(b)(4)), subject to the resident’s right to choose and refuse services. 42 CFR 483.10(c), 22 CCR §72527(4). Unless it is medically unavoidable, nursing homes must ensure that a resident’s abilities in daily living activities do not decline. 42 CFR §483.24(a).

Nursing homes are required to give equal attention to residents’ quality of life. “A nursing facility must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident.” 42 USC §1396r(b)(1)(A).

Beyond these core requirements, federal and California laws set many specific care standards. Key requirements are described below. Some care standards only apply to nursing homes that participate in the Medicare and Medi-Cal programs. Most California nursing homes participate in at least one of these programs. California laws and regulations apply to all licensed nursing homes in the state.

Care standards are government expectations; however, they don’t guarantee quality. If you are not receiving proper care, contact the long-term care ombudsman program or CANHR for advice, or file a formal complaint with the California Department of Public Health (DPH).

This guide summarizes key care standards on:

- Accommodation of needs
- Adequate staffing
- Bed rails
- Behavioral health care
- Call systems
- Care planning
- Continence and help with toileting
- Dementia care
- Dental, vision and hearing care
- Feeding tubes
- Fluids and hydration
- Food and nutrition
- Hospice care
- Infection control
- Medications, unnecessary drugs and chemical restraints
- Pain management
- Personal care
- Physician services
- Pressure sores
- Quality of life
- Refusing care
- Respiratory care
- Safety and preventing accidents
- Therapy services and mobility care
- Trauma-informed care
Laws and regulations are abbreviated as follows: California Health & Safety Code as “HSC,” Title 22 of the California Code of Regulations as “22 CCR,” Title 42 of the Code of Federal Regulations as “42 CFR,” and Title 42 of the United States Code as “42 USC.” For example, “42 USC §1396r(b)(2)” refers to Title 42 of the United States Code, at section 1396r, subsection (b), paragraph (2). The abbreviation “CMS” stands for The Centers for Medicare & Medicaid Services, the federal agency that manages the Medicare and Medicaid programs. CMS publishes official guidance on the federal nursing home regulations in Appendix PP of its State Operations Manual, which guidance is abbreviated as “SOM Appendix PP.”

**Accommodation of Needs**

A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences. 42 USC §1396r(c)(1)(A)(v), 42 CFR §483.10(e)(3). This key right means nursing homes cannot use one-size fits all approaches. Instead, they must individualize care, adapting such things as schedules, call systems, staff assignments and room arrangements to accommodate residents’ preferences, desires and unique needs. 42 CFR §483.10(c), (e), & (f). For example, if a resident refuses a bath because she prefers a shower or a different bathing method, such as in-bed bathing, prefers to bathe at a different time of day or on a different day, does not feel well that day, is uneasy about the aide assigned to help or is worried about falling, the resident’s preferences must be accommodated. SOM Appendix PP at F561.

If language or communication barriers exist between residents and staff, the nursing home is required to use interpreters or other measures to ensure adequate communication. 22 CCR §72501(f), see also 42 CFR 483.10(c)(1).

**Adequate Staffing**

Nothing is more important than staffing to quality of care, yet state and federal standards on staffing are far from ideal.

Both federal and California standards require a nursing home to have sufficient nursing and other staff to meet the needs of each resident at all times. 42 USC §1396r(b)(4)(C)(i)(I), 42 CFR §483.35, HSC §1276.65(d) & §1599.1(a), 22 CCR §72329(a) & §72501(e). Each facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. 42 CFR §483.35. Due to poor enforcement of these requirements, few nursing homes have sufficient staff.

On an annual basis, nursing homes must conduct an assessment to determine the care needs of its residents and the staff competencies that are necessary to meet them. 42 CFR §483.70(e). The facility must employ the professional staff necessary to meet resident needs and otherwise comply with the federal requirements. 42 CFR §483.70(f)(1). The professional staff must be licensed, certified or registered in accordance with state laws. 42 CFR §483.70(f)(2).

Unlike the federal government, California has set minimum numerical staffing requirements for skilled nursing facilities. They are required to provide a minimum of 3.5 hours of direct care by nurses and certified nursing assistants (CNAs) per resident each day, with at least 2.4 of those hours provided by CNAs. HSC §1276.65. Skilled nursing facilities are able to seek waivers of these requirements from the Department of Public Health, in which case they are required to provide at least 3.2 hours of direct care per resident each
day. HSC §1276.65(l). The California minimum staffing requirements are not adequate to meet the needs of today’s nursing home residents.

A skilled nursing facility must have a full-time director of nursing who is a registered nurse (RN). 42 CFR §483.35(b), 22 CCR §72327. Additionally, it is required to have an RN on duty for at least 8 consecutive hours a day, 7 days a week. 42 CFR §483.35. If the facility is licensed for 100 beds or more, it must have an RN on duty at all times. 22 CCR §72329. Facilities under 100 beds must have RNs or licensed vocational nurses (LVNs) on duty at all times. 42 CFR §483.35, 22 CCR §72239.

Skilled nursing facilities or units within them that contract with Medi-Cal to provide subacute care have higher staffing requirements. Freestanding skilled nursing facilities must provide a minimum daily average of 3.8 licensed nursing hours and 2.0 CNA hours per resident day, while hospital based subacute units must provide a minimum daily average of 4.0 licensed nursing hours and 2.0 CNA hours per resident day. Subacute units that do not utilize CNAs must employ sufficient licensed nursing staff to provide 4.8 actual licensed nursing hours per patient day. 22 CCR 51215.5(e).

In a clearly visible place, a facility must post daily, for each shift, the current number of licensed and unlicensed nursing staff directly responsible for resident care. 42 USC §1396r(b)(8), 42 CFR §483.35(g), California Health & Safety Code §1276.65(f).

Additionally, nursing facilities are required to electronically submit direct care staffing information per day to CMS through its Payroll-Based Journal (PBJ) system. 42 CFR §483.70(q), SOM Appendix PP at F851.

**Bed Rails**

In response to longstanding safety concerns, CMS established detailed standards on bed rails that restrict but do not completely forbid their use in nursing homes. Many residents have died or suffered serious injuries from entrapment in bed rails, leading CMS to strengthen its standards about their use.

The following statement by CMS in its guidance on the physical restraint standard describes the hazards of bed rails when misused.

> Residents who are cognitively impaired are at a higher risk of entrapment and injury or death caused by restraints. Residents in a bed with bed rails have attempted to exit through, between, under, over, or around bed rails or have attempted to crawl over the foot board, which places them at risk of serious injury or death. Serious injury from a fall is more likely from a bed with raised bed rails than from a bed where bed rails are not used. In many cases, the risk of using the bed rails may be greater than the risk of not using them as the risk of restraint-related injury and death is significant. SOM Appendix PP at F604.

The federal standards on bed rail use focus on four factors: (1) Are they being used as a physical restraint? (2) Were appropriate alternatives attempted? (3) Was informed consent obtained? and (4) Are they used safely?

**Are they being used as a restraint?** If so, their use is generally prohibited. Residents have the right to be free from any physical restraint imposed for purposes of discipline or convenience, and not required to treat the resident’s medical symptoms. 42 CFR §483.10(e), 42 CFR §483.12(a). A bed rail that keeps a resident from voluntarily getting out of bed in a safe manner due to his/her physical or cognitive inability to lower the bed rail independently is considered a restraint. SOM Appendix PP at F604.

Bed rails may have the effect of restraining one individual but not another, depending on the individual resident’s conditions and circumstances. For example, the use of partial bed rails may assist an independent
resident to enter and exit the bed independently and would not be considered a physical restraint. To determine if a bed rail is being used as a restraint, the resident must be able to easily and voluntarily get in and out of bed when the equipment is in use. If the resident cannot easily and voluntarily release the bed rails, the use of the bed rails may be considered a restraint. SOM Appendix PP at F604.

Were appropriate alternatives attempted? If not, their use is prohibited. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. 42 CFR §483.25(n).

Even when bed rails are properly designed to reduce the risk of entrapment or falls, are compatible with the bed and mattress, and are used appropriately, they can present a hazard to certain individuals, particularly to people with physical limitations or altered mental status, such as dementia or delirium. SOM Appendix PP at F700.

Was informed consent obtained? If not, their use is prohibited. The facility must review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. 42 CFR §483.25(n).

At a minimum, the facility must provide the following information to the resident or, if applicable, the resident representative in seeking informed consent:

- What assessed medical needs would be addressed by the use of bed rails;
- The resident’s benefits from the use of bed rails and the likelihood of these benefits;
- The resident’s risks from the use of bed rails and how these risks will be mitigated; and
- Alternatives attempted that failed to meet the resident’s needs and alternatives considered but not attempted because they were considered to be inappropriate.

SOM Appendix PP at F700.

Are they used safely? If not, their use is prohibited. To ensure safe use, the facility must:

- Ensure the correct installation, use and maintenance of bed rails. 42 CFR §483.25(n).
- Assess the resident for risk of entrapment prior to installation. 42 CFR §483.25(n)(1). The resident assessment must include an evaluation of the alternatives that were attempted prior to the installation or use of a bed rail and how these alternatives failed to meet the resident’s assessed needs. SOM Appendix PP at F700.
- Ensure that the bed’s dimensions are appropriate for the resident’s size and weight. 42 CFR §483.25(n)(3).
- Follow the manufacturers’ recommendations and specifications for installing and maintaining bed rails. 42 CFR §483.25(n)(4).
- Conduct regular inspection of all bed frames, mattresses and bed rails as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress and bed frame are compatible. 42 CFR §483.90(d)(3).

Behavioral Health Care

Federal regulations require nursing homes to provide behavioral health care and services to residents when needed to attain or maintain their emotional and mental well-being, including, but not limited to, preventing and treating mental and substance abuse disorders. 42 CFR §483.40.

A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder (PTSD), must receive appropriate treatment and services. Facilities must also ensure that residents who do not have a history of these conditions do not display a pattern of decreased social interaction or increased withdrawn, angry or depressive behaviors.
unless their clinical condition demonstrates that development of such a pattern was unavoidable. 42 CFR §483.40(b).

Some examples of treatment and services for psychosocial adjustment difficulties may include providing residents with opportunities for autonomy; arrangements to keep residents in touch with their communities, cultural heritage, former lifestyle, and religious practices; and maintaining contact with friends and family. SOM Appendix PP at F742.

The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skill sets to care for its residents who have mental and psychosocial disorders, as well as those with a history of trauma and/or post-traumatic stress disorder, and must be able to implement non-pharmacological interventions. 42 CFR §483.40(a). Non-pharmacological interventions are approaches to care that do not involve medications, generally directed towards stabilizing or improving a resident’s mental, physical and psychosocial wellbeing. SOM Appendix PP at F741.

If a resident needs rehabilitative services such as physical, speech and occupational therapies and rehabilitative services for mental disorders and intellectual disability, the facility must either provide the required services or obtain them from a Medicare and/or Medicaid provider of specialized rehabilitative services. 42 CFR §483.40(c).

Nursing facilities are required to provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial wellbeing of each resident. 42 USC §1396r(b)(4)(A)(ii), 42 CFR 483.40(d).

Call Systems

Residents must have a means of directly contacting caregivers when in their rooms and toilet and bathing areas. The facility’s call system must allow residents to call for staff through a system that relays the call directly to a staff member or to a centralized work area from each resident’s bedside (or other sleeping accommodations) and from toilet and bathing facilities. 42 CFR §483.90(g), SOM Appendix PP at F919, HSC §1599.1(f), 22 CCR §72631.

Resident call signals shall be answered promptly. 22 CCR §72315(m).

Residents who are unable to use call bells or otherwise communicate their needs should be checked frequently (e.g., each half hour) for safety, comfort, bathroom needs, positioning, offering fluids and other care needs. SOM Appendix PP at F725, 42 CFR §483.35(a).

Care Planning

Nursing homes must establish a comprehensive, individualized care plan for each resident that spells out care needs and how they will be met. The care planning process is an important opportunity for residents and their representatives to address care concerns.

Within 48 hours of a resident’s admission, a nursing home must develop and implement a baseline care plan that includes instructions needed to provide effective care of a resident. This initial plan identifies essential goals for the resident, including physician, dietary, therapy and social service orders. The facility must give a summary of the baseline care plan to the resident and any representative. 42 CFR §483.21(a).

Assessing the resident’s needs is a critical part of the care planning process. 42 CFR §483.20, 22 CCR 72311. California requires initial assessments to be completed within 7 days after admission. 22 CCR
§72311(a)(1)(A). Assessments must be updated at least quarterly and comprehensively reviewed every 12 months and whenever there is a significant change in a resident’s condition. 42 CFR §483.20.

Within 7 days of the initial assessment, the facility must develop a comprehensive, person-centered care plan for each resident. 42 USC §1396r(b), 42 CFR §483.21. “Person-centered” means residents are supported to make their own choices about their care and have control over their daily lives. 42 CFR §483.5. The care plan is developed by an interdisciplinary team of facility staff, including a nurse aide with responsibility for the resident, in conjunction with the resident and her representatives.

Good care plans address all aspects of a resident’s life in the nursing home and are a custom-made strategy for how the staff will help and support the resident each day. However, most care plans fall far short of these expectations because nursing homes often design the care planning process to serve the needs of staff rather than residents. Whenever possible, residents and their representatives should exercise their rights to participate in care plan meetings, give information, ask questions, offer suggestions, make choices about their care, review care plan documents and accept or refuse offered care.

For more information on residents’ rights in the care planning process, see CANHR’s Making Care Plans Work and A Guide to the Revised Nursing Facility Regulations on Assessment, Care Planning, and Discharge Planning, a joint publication of Justice in Aging, The National Consumer Voice for Quality Long Term Care and the Center for Medicare Advocacy.

Continence and Help with Toileting

Many nursing home residents require care for incontinence, the inability to control the bladder or bowel. Incontinence and lack of toileting assistance cause many serious problems, including discomfort, skin rashes, pressure sores, falls, isolation and psychological harm.

Incontinence is not a normal part of aging and is often reversible. It is often due to medications or treatable health conditions. Each resident with bladder or bowel control problems must be promptly assessed and be provided treatments and care to help restore continence and to prevent urinary tract infections. 42 CFR §483.25(e), 22 CCR §72315(i), HSC §1599.1(b).

Catheters cannot be used without valid medical justification. 42 CFR §483.25(e)(2)(i). Catheters cause discomfort, limit mobility and increase the risk of infection, bladder stones and cancer. If a catheter is used, the resident must be assessed for removal of the catheter as soon as possible unless the resident’s clinical condition demonstrates that catheterization is necessary. 42 CFR §483.25(e)(2)(iii).

Residents who are continent of bowel and bladder on admission must receive services and assistance to maintain continence unless their clinical conditions make continence impossible to maintain. 42 CFR §483.25(e)(1), 22 CCR §72315(i). Many residents are not incontinent but do need help with toileting. For example, a resident with limited mobility may need help to reach the toilet. Or a resident with dementia may need reminders to use the toilet on a regular basis. Nursing homes must help these residents use the toilet as often as needed. 42 CFR §483.24(a)&(b).

Dementia Care

The term “dementia care” refers to care of persons who have some form of dementia. About half of all nursing home residents have some type of dementia.

It is of upmost importance that nursing homes be experts in dementia care, yet many nursing home administrators and caregivers lack even a basic understanding of dementia care principles.
Federal standards on dementia care are broad and vague. They require nursing homes to ensure that a resident who displays or is diagnosed with dementia receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental and psychosocial wellbeing. 42 CFR §483.40(b)(3). Facilities must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to meet this standard. 42 CFR §483.40(a).

The care of residents with dementia, as well as other residents, must be based on a person-centered approach. 42 CFR §483.21. This approach involves learning about and respecting each resident’s unique values, preferences, abilities, personality, and personal history. Each resident’s care should be customized to adapt personal care, sleep schedules, meals, bathing methods, communications, activities, daily routines, caregiver and roommate assignments, and other aspects of life in the facility to her or his preferences.

Enlightened care providers are increasingly turning to “comfort care” to enhance the quality of life for residents who have dementia. As its name suggests, comfort care strives to keep residents comfortable through a nurturing, individualized approach that focuses on their emotional, social and spiritual needs, as well as their medical and personal care needs. The goal of comfort care is to keep each resident comfortable and free from distress by:

- Anticipating their needs;
- Knowing them so well that basic needs never become major problems;
- Embracing a philosophy of individualized care;
- Adjusting the pace, approach and communications with them to suit the needs of people with dementia;
- Recognizing and treating pain aggressively; and
- Treating family and friends as partners in care.

Caring Kind has published an excellent consumer guide on comfort care, Finding Comfort: Living with Advanced Dementia in Residential Care, A Consumer Guide.

Instead of person-centered and comfort care, many nursing homes use powerful antipsychotic drugs and other types of psychoactive drugs to sedate and subdue residents with dementia into submission when they are distressed. Despite federal and California campaigns since 2011 to reduce the rampant drugging of nursing home residents with dementia, California nursing homes continue to give dangerous antipsychotic drugs to about one of every five residents. To learn about the drugging epidemic and how to fight it, read CANHR’s guide: Toxic Medicine – What You Should Know to Fight the Misuse of Psychoactive Drugs in California Nursing Homes.

Dental, Hearing and Vision Care

A resident’s care plan must comprehensively address his or her care needs, including needed dental, hearing and vision services.

**Dental Care:** Nursing homes must provide or arrange for routine and emergency dental services to meet the needs of each resident. 42 USC §1396r(b)(4)(vi), 42 CFR §483.55. Routine dental services means an annual exam, dental X-rays as needed, dental cleaning, fillings, denture adjustments, smoothing of broken teeth and limited prosthodontic procedures. Emergency dental services includes services needed to treat an episode of acute pain in teeth, gums or palate; broken or damaged teeth; or any other problem of the oral cavity that requires immediate attention by a dentist. SOM Appendix PP at F790 and F791.

A dentist must be available for each resident. The dentist can be directly employed by the facility or the facility can have a written contractual agreement with a dentist. SOM Appendix PP at F790 and F791.
Facilities are required to assist residents in making appointments and arranging transportation to dental offices if care is provided offsite. 42 CFR §483.55(a)(4)&(b)(2).

If a resident’s dentures are lost or damaged, the nursing home must promptly, within three days, refer residents for dental services. If a referral does not occur within three days, the facility must document what it did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. 42 CFR §483.55(a)(5)&(b)(3). Each facility must have a policy identifying those circumstances when the loss or damage of dentures is the facility’s responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with the facility policy to be the facility’s responsibility. 42 CFR §483.55(a)(3)&(b)(4).

**Hearing and Vision Care:** Facilities must arrange treatment that maintains residents’ abilities to see and hear. 42 CFR §483.25(a). If a resident needs hearing or vision care or assistive devices, the nursing home should make necessary appointments and arrange transportation if services are delivered away from the facility. 42 CFR §483.25(a)(1)&(2). Assistive devices to maintain vision include, but are not limited to, glasses, contact lenses, magnifying lens or other devices that are used by the resident. Assistive devices for hearing include hearing aids, amplifiers or other devices. SOM Appendix PP at F685. The facility should help residents and their families locate and utilize any available community resources or payment programs, including Medicare and Medi-Cal. SOM Appendix PP at F685.

**Paying for Dental, Hearing and Vision Care:** Residents may have to pay for dental, hearing and vision services they receive unless they have Medi-Cal or other health insurance that covers these services. Medi-Cal does cover this care with some limits.

If a resident on Medi-Cal needs dental, hearing or vision services not covered by Medi-Cal (or other uncovered medical expenses), he or she can deduct the costs from the monthly share of cost set by Medi-Cal. A current physician’s prescription is necessary and must be put in the resident’s record at the facility. This prescription must be part of the physician’s plan of care. After a copy of the prescription and the bill is presented to the facility, it will deduct the cost from that month’s share of cost and bill the resident for the remaining share of cost. *Johnson v Rank* (ND Cal 1989) 110 FRD 99, ACWD Letter No. 89-54 (July 24, 1989), 42 CFR §435.733, 42 CFR §435.832 and 42 CFR §483.55(b)(5).

**Feeding Tubes**

Tube feeding is the delivery of nutrients through a feeding tube directly into the stomach or small intestine. There are various types of feeding tubes.

Feeding tubes should generally be used as a last resort because they lead to a loss of functioning and can cause serious medical and psychological problems. They should not be used for residents who are able to swallow and who can get adequate nutrition by eating. Nor should they be used due to lack of caregivers to help residents with meals.

Subject to the resident’s consent, a feeding tube can be used if it is clinically indicated. 42 CFR §483.25(g)(4).

When a resident or resident’s representative exercise the right to refuse artificial nutrition or hydration, the facility is responsible for discussing the risks and benefits associated with that decision and offer alternatives, as appropriate. SOM Appendix PP at F692, 42 CFR §483.25(g).

The facility must ensure that a resident maintains acceptable standards of nutritional status unless the resident’s clinical condition or preferences demonstrate that this is not possible. 42 CFR §483.25(g)(1).
Residents fed by tube must receive the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration and other adverse symptoms. 42 CFR §483.25(g)(5).

If a feeding tube is being used, the nursing home must do what it can to help the resident take food by mouth again as soon as possible. 42 CFR §483.25(g)(5).

For residents with end stage dementia, studies have shown that tube feeding does not necessarily extend life, prevent aspiration pneumonia, improve function, or limit suffering. SOM Appendix PP at F692 and F693, 42 CFR §483.25(g).

**Fluids and Hydration**

Nursing homes must offer each resident with sufficient fluids, consistent with their needs and preferences, to maintain proper hydration and health. 42 CFR §483.25(g)(2), 42 CFR §483.60(d)(6), 22 CCR 72315(h). Residents should be offered a variety of fluids during and between meals, within their reach, and be assisted with drinking as needed. SOM Appendix PP at F692.

Proper hydration is a critical aspect of nutrition among nursing home residents. SOM Appendix PP at F807.

Nonetheless, many nursing home residents become dehydrated because they are not given sufficient fluids or are not assisted to drink often enough. Symptoms of dehydration include dizziness, confusion, constipation, fever, decreased urine output, urinary tract infections, pneumonia, and pressure sores and skin infections. Severe dehydration can lead to serious illness and death.

A nursing home is required to record fluid intake and output if ordered by a resident’s physician and for each resident with an indwelling catheter. 22 CCR §72315(j). A licensed nurse shall evaluate and summarize the intake and output records each week.

Some residents receive intravenous (IV) fluid treatments to maintain hydration and nutrition, which are called parenteral fluids. These treatments must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive care plan and the resident’s goals and preferences. 42 CFR §483.25(h).

**Food and Nutrition**

The nursing home must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. 42 USC §1396r(b)(4)(A)(iv), 42 CFR §483.60, 22 CCR §72335, HSC §1599.1(c). It shall also ensure that a resident maintains acceptable standards of nutritional status unless the resident’s clinical condition or preferences demonstrate that this is not possible. 42 CFR §483.25(g)(1).

Resident preferences and choices about food must be respected. The facility must make reasonable efforts to provide food that is appetizing to and culturally appropriate for residents. This means learning the resident’s needs and preferences and responding to them. For residents with dementia or other barriers or challenges to expressing their preferences, facility staff should document the steps taken to learn what those preferences are. 42 CFR §483.60(c), SOM Appendix PP at F803.

With some qualifications, residents who have nutritional problems may choose preferred foods over therapeutic or mechanically altered diets. Federal regulators call this a “liberalized diet.” However, a nursing home must inform a resident and her representative about the risks and benefits of a liberalized diet, work with the resident’s physician and its clinical staff to determine the best plan for the resident, and accommodate the resident’s needs, preferences and goals. SOM Appendix PP at F692.
California requires nursing homes to offer residents vegan meal options, described as wholesome, plant-based meals of such variety as to meet the needs of residents in accordance with their physicians’ orders. HSC §1265.10.

Food served to residents must:
- Be prepared by methods that conserve nutritive value, flavor and appearance;
- Be palatable, attractive and at a safe and appetizing temperature;
- Be prepared in a form to meet individual needs;
- Accommodate resident allergies, intolerances and preferences; and
- Be stored, prepared, distributed, and served under sanitary conditions.
42 CFR §483.60(d)&(i), 22 CCR §§72343 – 72349.

Although the facility must procure food from sources approved or considered satisfactory by government authorities, this provision does not preclude residents from eating foods not procured by the facility. 42 CFR §483.60(i)(1).

The facility must provide therapeutic diets to residents with nutritional problems, subject to physician orders. Therapeutic diets shall be planned, prepared and served with supervision or consultation from the dietitian. 42 CFR §483.60(e), 22 CCR §72339.

A resident’s ability to eat should not diminish unless it is clinically unavoidable. 42 CFR §483.24(a)&(b). The facility must provide the necessary care and services to prevent this from occurring.

Each resident requiring help in eating shall be provided with assistance when served, and shall be provided with training and adaptive equipment in accordance with identified needs, based upon resident assessment, to encourage independence in eating. 22 CCR §72315(g), 42 CFR §483.60(g).

Residents must receive at least three meals daily, at normal mealtimes or in accordance with the resident needs, preferences, requests and plans of care. 42 CFR §483.60(f)(1), 22 CCR §72355. There must be no more than a 14-hour span between the last meal and breakfast the following day. 22 CCR §72335, 42 CFR §483.60(f)(2). Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times. 42 CFR §483.60(f)(3). Bedtime snacks must be offered. 22 CCR §72335(a)(3).

When residents choose not to eat food that is initially served or request a different meal choice, they must receive appealing options of similar nutritive value. 42 CFR §483.60(d)(5), 22 CCR §72335(a)(2).

Nursing homes must notify a resident’s physician immediately if there are signs of malnutrition, such as a weight loss of 5 pounds or more within a 30-day period. 22 CCR §72311(a)(3)(D). A comprehensive nutritional assessment should be completed on any resident identified as being at risk for unplanned weight loss/gain and/or compromised nutritional status. Under federal guidelines, weight losses of 5% in one month, 7.5% in three months and 10% in 6 months are considered significant. Losses greater than those levels are considered severe. SOM Appendix PP at F692.

Menus must meet national dietary standards, be approved by the dietitian and be planned with consideration of the residents’ cultural backgrounds and food habits. Current menus must be posted. 22 CCR §72341.

Table service shall be provided to all residents who can and wish to eat at a table, served at tables of appropriate height. 22 CCR §72335(a)(4). Dining rooms must be well-lighted and well-ventilated and must be adequately furnished and have sufficient space. 42 CFR §483.90(h). SOM Appendix PP at F920.
Hospice Care

Nursing home residents who are near the end-of-life often receive hospice services from a hospice provider. This section describes key hospice care standards that apply to nursing and skilled nursing facilities. It does not cover separate licensing and certification standards that apply to hospices, nor does it address Medicare and other health insurance coverage of hospice care.

Hospice is a program of care and support for people who are terminally ill and their families. It focuses on giving comfort, pain relief and emotional support to someone who is dying instead of trying to cure the person’s illness. Persons on hospice care usually have a medical prognosis of 6 months or less to live if the illness runs its normal course. When hospice care is delivered in a nursing home, it involves shared responsibilities between the hospice and the nursing home.

Resident Choice: Selecting hospice care is a choice for nursing home residents who qualify for it, never a requirement. Those who enroll can disenroll at any time. Residents who are near end-of-life can choose to continue full care and treatment or other options. Some may choose palliative care delivered by the facility, which is resident and family-centered care that optimizes quality of life by anticipating, preventing and treating suffering.

However, there is no requirement that a nursing home allow a hospice to provide hospice care and services in the facility. 42 CFR §483.70(o)(1)(i) & (ii), SOM Appendix PP at F849. If a nursing home has made arrangements with one or more hospices to provide services in the nursing home, it must inform each resident before and periodically during the resident’s stay of hospice services available in the nursing home. 42 CFR §483.10(g)(16), SOM Appendix PP at F849. Residents have the right to choose among hospice providers that have agreements with the facility. SOM Appendix PP at F849.

There are at least three options if a resident chooses a hospice that does not have an agreement with the nursing home. One, the nursing home could establish a written agreement with the hospice and honor a resident’s choice of hospice provider. Two, a resident could transfer to a nursing home that has an agreement with the preferred hospice provider or will establish one. Three, a resident could choose to remain in the current nursing home and not elect hospice care. SOM Appendix PP at F849.

The quality of hospices varies tremendously. If someone seeking a nursing home anticipates needing hospice care, it is best to select a facility that already has an agreement with a hospice provider of choice. Ask hospices of choices which nursing homes they have agreements with.

Written Nursing Facility Agreement with Hospice: If a nursing home has made arrangements with one or more hospices to provide services in the nursing home, there must be a written agreement describing the responsibilities between each hospice and the nursing home prior to the hospice initiating care for a resident who has elected the hospice benefit. The written agreement applies to the provision of all hospice services for any nursing home resident receiving services from the specific hospice and does not need to be rewritten for each resident. There are extensive requirements for the written agreements. 42 CFR 483.70(o)(2)(ii), SOM Appendix PP at F849.

Hospice Role: The hospice retains primary responsibility for providing hospice care and services, based on the resident’s assessments and choices. This includes, but is not limited to: providing medical direction and management of the resident; nursing; spiritual, dietary and bereavement counseling; social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident’s terminal illness and related conditions. 42 CFR §483.70(o)(2)(ii)(H), SOM Appendix PP at F849.
The hospice is also responsible for determining the appropriate course of hospice care, including the determination to change the level of services provided. 42 CFR §483.70(o)(2)(ii)(F).

**Nursing Facility Role:** The nursing home is responsible to furnish 24-hour room and board care, meet personal care and nursing needs in coordination with the hospice, and ensure that the level of care provided to a resident is appropriately based on the individual’s needs. 42 CFR §483.70(o)(2)(ii)(G).

Another facility responsibility is to ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility. The nursing home staff must monitor the delivery of care in order to assure that the hospice provides services to the resident in a way that meets his or her needs in a timely manner. 42 CFR §483.70(o)(2)(ii)(E), SOM Appendix PP at F849.

The nursing home must immediately contact and communicate with the hospice staff regarding any significant changes in the resident’s status, clinical complications or emergent situations. 42 CFR §483.70(o)(2)(ii)(E), SOM Appendix PP at F849.

**Coordinated Plan of Care:** The hospice is responsible for establishing the hospice plan of care in coordination with the resident/representative, the nursing home, and the resident’s nursing home attending physician. The coordinated plan must identify the provider responsible for performing each specific service that has been agreed upon. It may be divided into two portions, one maintained by the nursing home and the other maintained by the hospice, but each provider must be aware of the location and content of the coordinated plan of care. Moreover, the plan must be current and internally consistent in order to assure that the needs of the resident for both hospice care and nursing home care are met at all times. 42 CFR §483.70(o)(2)(ii)(B), SOM Appendix PP at F849.

Each nursing home providing hospice care under a written agreement must ensure that each resident’s written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the facility to attain or maintain the highest practicable physical, mental and psychosocial wellbeing of the resident. 42 CFR §483.70(o)(4).

**Designated Staff Member to Coordinate Care:** The nursing home must identify and designate, in writing, a member of the facility’s interdisciplinary team to assume the responsibilities for collaborating and coordinating activities between the nursing home and the hospice. Its designee must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. This person is responsible for the following: coordinating facility and hospice staff participation in the hospice planning process; communicating with hospice representatives and other healthcare providers on care for the resident’s terminal illness; ensuring communications with the hospice medical director and other practitioners participating in care to the resident; obtaining specified information from the hospice; and ensuring that the facility staff provides orientation to hospice staff on its policies and procedures, resident rights, and record keeping requirements. 42 CFR §483.70(o)(3), SOM Appendix PP at F849.

**Hospice Physician:** Residents who enroll in a hospice may choose their nursing home attending physician to serve as the hospice attending physician or select another physician for this role. SOM Appendix PP at F849.

**Infection Control**

**Federal Requirements:** Primary federal infection control standards are found at 42 CFR 483.80. They require nursing homes to establish an infection prevention and control program that includes a system to prevent, identify, report, investigate, and control infections and communicable diseases for all residents, staff, volunteers, visitors and other individuals providing services under contractual arrangements. The
program must be governed by written standards, policies and procedures that include: a system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; reporting protocols; standard and transmission-based precautions; policies for when and how to isolate a resident; protocols for prohibiting employees with communicable diseases or infections from direct contact with residents or their food; and hand hygiene procedures. Additionally, the federal regulation requires nursing homes to have an antibiotic stewardship program to monitor antibiotic use and a system for recording infection control incidents and corrective measures.

**Infection Preventionist:** Both the federal regulation at 42 CFR 483.80(b) and California law require nursing facilities to designate one or more persons as an infection preventionist, who is responsible for the facility’s infection prevention and control program. California law requires skilled nursing facilities to have a full-time, dedicated infection preventionist, which role may be filled either by one or two persons. HSC §1255.9, AB 2644 (2020) as amended by AB 1585 (2021), see also CDPH AFL 20-85 and AFL 21-51. The infection preventionist (IP) must have primary professional training as a licensed nurse, medical technologist, microbiologist, epidemiologist, public health professional or other health related field. IPs must be qualified by education, training, clinical or health care experience, or certification, and must have completed specialized training in infection prevention and control. CDPH established recommended minimum number of training hours and content for IPs in AFL 20-84. The IP hours cannot be included in the 3.5 direct care service hours per patient day required in a skilled nursing facility.

**2020 Legislation:** AB 2644 (2020) also requires skilled nursing facilities to have a plan in place for infection prevention quality control and to ensure all health care personnel receive infection prevention and control training on an annual basis. HSC §1255.9(b), see also CDPH AFL 20-85.

**Medications, Unnecessary Drugs and Chemical Restraints**

Nursing home residents often take a large number of prescribed medications, which sometimes cause adverse effects and do more harm than good. In order to ensure that medications are available and used safely, federal and state rules require nursing homes and physicians to properly order, record, store, administer and monitor medications. Despite the standards, medication problems are common, such as medication errors, over-prescribing drugs, and chemical restraint.

Key medication requirements are summarized below:

**Consent:** Residents and their legal representatives have the right to consent to or to refuse any treatment, including use of medications. 22 CCR §72527(a)(4), 42 CFR §483.10(c). Physicians must seek consent before ordering or changing medications.

**Choice of Pharmacy:** Residents have the right to choose their own pharmacy, subject to certain limitations. HSC §1320, 22 CCR §72527(a)(23).

**Timely Availability:** Nursing homes must have 24-hour arrangements with one or more pharmacies to ensure that residents receive ordered medications on a timely basis. 22 CCR §§72353 – 72355, 42 CFR §483.45. A drug, whether prescribed on a routine, emergency, or as needed basis, must be provided in a timely manner. 22 CCR §§72313 and 72355. Doses shall be administered within one hour of the prescribed time unless otherwise indicated by the prescriber. 22 CCR 72313(a)(6).

**Who Can Administer:** Generally, medications must be administered by licensed nurses or medical personnel. 22 CCR §72313(a)(5). Unlicensed staff may administer certain laxatives, non-prescription lotions, medicinal shampoos and baths, subject to specific training, demonstrated competence and direct supervision by licensed nursing or medical personnel. 22 CCR §72313(a)(5)(B). The person who administers the drug or treatment must record the date, time, and dosage in the resident’s individual medication record. 22 CCR §72313(c).
**Medication Errors:** Medications shall be administered as prescribed. 22 CCR §72313(a)(2). Nursing homes must ensure that residents are free of any significant medication errors and that medication error rates are not 5 percent or greater. 42 CFR §483.45(f). A medication error is an instance when the facility’s preparation or administration of a medication is not in accordance with either the prescriber’s orders, manufacturer’s specifications, or accepted professional standards and principles. SOM Appendix PP at F760. A medication error is considered significant when it causes the resident discomfort or jeopardizes his or her health and safety. SOM Appendix PP at F760.

**Ban on Sharing:** It is illegal to give a medication to someone other than the resident for whom it was prescribed. 22 CCR §72313(b).

**Quality Control:** Each nursing home is required to obtain services from a licensed pharmacist to assess its medication system and to review the drug regimen of each resident on a monthly basis. 42 CFR §483.45(b)&(c), 22 CCR §72375. The pharmacist is required to report in writing any irregularities to the resident’s attending physician, the facility’s medical director, administrator, and director of nursing, who must act on the reports. 42 CFR §483.45(c), 22 CCR §72375. The attending physician must document in the resident’s medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident’s medical record. 42 CFR §483.45(c)(4)(iii).

**Unnecessary Drugs:** Over-prescribing medications is a dangerous problem in many nursing homes. Federal law prohibits nursing homes from using unnecessary drugs, which are defined as any drug when used: (1) in excessive dose; (2) for excessive duration; (3) without adequate monitoring; (4) without adequate indications for its use; or (5) in the presence of adverse consequences which indicate the dose should be reduced or discontinued. 42 CFR §483.45(d).

**Medication Management:** A facility’s medication management process shall support and promote:

- Involving the resident, representative and family;
- Evaluating the underlying causes of a resident’s physical, behavioral, mental and psychosocial signs and symptoms;
- Using non-pharmacological approaches unless contraindicated to minimize need for medications;
- Selecting medications based on relative benefits and risks to the individual resident;
- Selecting and using medications in doses and for the duration appropriate to each resident’s preferences, clinical conditions, age, and underlying causes of symptoms;
- Respecting resident choice and discussing appropriate alternatives when a resident declines a medication;
- Managing medications consistent with a resident’s advance directive; and
- Monitoring medications for efficacy and adverse consequences.

**Protections from Chemical Restraint:** Federal law gives residents the right to be free from chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident’s medical symptoms. 42 USC §1396r(c)(1)(A)(ii), 42 CFR §483.10(e), 42 CFR §483.12. A chemical restraint is defined as “any drug that is used for discipline or staff convenience and not required to treat medical symptoms.” SOM Appendix PP at F605.

**Psychotropic and antipsychotic drugs:** Federal law also restricts the use of psychotropic and antipsychotic drugs due to the long history of nursing homes routinely using them to chemically restrain residents. Psychotropic drugs may be administered only on the orders of a physician and only as part of a plan designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually an independent, external consultant reviews the appropriateness of the drug plan. 42 USC §1396r(c)(1)(D).
A psychotropic drug is defined as any drug that affects brain activities associated with mental processes and behaviors, including, but not limited to, drugs in the following categories: antipsychotic; antidepressant; antianxiety; and hypnotic. 42 CFR §483.45(c)(3).

Nursing homes must ensure that –
1. Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;
2. Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;
3. Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record;
4. PRN (as needed) orders for psychotropic drugs are limited to 14 days subject to exceptions;
5. PRN orders for antipsychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.

42 CFR §483.45(e).

Use of psychotropic medications, other than antipsychotics, should not increase when efforts to decrease antipsychotic drugs are being implemented. SOM Appendix PP at F758.

Other medications not classified as antipsychotic, antidepressant, antianxiety, or hypnotic medications can also affect brain activity and should not be used as a substitution for another psychotropic medication unless prescribed with a documented clinical indication consistent with accepted clinical standards of practice and in accordance with federal regulations. Categories of medications which affect brain activity include antihistamines, anti-cholinergic medications and central nervous system agents used to treat conditions such as seizures, mood disorders, pseudobulbar affect, and muscle spasms or stiffness. The requirements pertaining to psychotropic medications apply to these types of medications when their documented use appears to be a substitution for another psychotropic medication rather than for the original or approved indication. SOM Appendix PP at F758.

Careful monitoring of psychotropic drugs is required. Nursing homes must evaluate the effectiveness of these drugs and monitor for potential adverse consequences. SOM Appendix PP at F758.

For more information on residents’ rights to be protected from chemical restraints, see CANHR’s guide, Toxic Medicine: What You Should Know to Fight the Misuse of Psychoactive Drugs in Nursing Homes.

Pain Management

It is estimated that 80 percent of more of nursing home residents live with pain. Residents are at high risk for having pain that affects function, impairs mood and mobility, disturbs sleep and harms their quality of life. SOM Appendix PP at F697.

Each nursing facility must ensure that pain management is provided to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plan and the residents’ choices related to pain management. 42 CFR §483.25(k).

To prevent or manage pain, a nursing home is expected to:
• Recognize when the resident is experiencing pain and identify circumstances when pain can be anticipated;
• Evaluate existing pain and assess the causes; and
• Manage or prevent pain. SOM Appendix PP at F697.

Facilities are expected to monitor, recognize and respond to pain experienced by residents who cannot verbally report it, such as is often the case for residents who have dementia and other types of cognitive impairments. SOM Appendix PP at F697.

They must also have a consistent process to assess pain by qualified staff. Facility staff are responsible for obtaining as much information as possible and evaluating a resident’s pain through all available means. SOM Appendix PP at F697.

Based on the evaluation, the facility must develop, implement, monitor and revise interventions to prevent or manage a resident’s pain, in collaboration with the resident, resident representative and treating physicians and other health care professionals. Pain management approaches should follow pertinent professional standards of practice and identify who is to be involved in managing the pain and implementing the care or supplying the services. SOM Appendix PP at F697.

Federal guidance urges prescribers to use caution when prescribing opioids due to increasing opioid addiction, abuse and overdoses. SOM Appendix PP at F697.

Non-pharmacological interventions should be considered when appropriate, such as altering the environment for comfort. Research supports physical activity and exercise as a part of most treatment programs for chronic pain. Some examples of non-pharmacologic interventions are repositioning residents; heat and cold treatments; massage, acupuncture or chiropractic therapies; exercises; restorative nursing; relaxation techniques; music therapy, to name a few. SOM Appendix PP at F697.

Personal Care

Nursing homes must give residents necessary assistance with personal needs, such as bathing, eating and dressing. 42 CFR 483.24(b), 22 CCR §72315(d). These needs are sometimes referred to as activities of daily living.

Unless it is clinically unavoidable, the nursing home must ensure that a resident’s abilities to carry out activities of daily living do not diminish. 42 CFR §483.24(a).

Activities of daily living include, but are not limited to, bathing, dressing, grooming, oral care, eating, mobility, walking, using the bathroom, transferring and communicating. 42 CFR §483.24(b).

A nursing home must provide necessary care and services to residents who need help with maintaining good nutrition, grooming and personal and oral hygiene. 42 CFR §483.24(a)(2).

Oral care refers to maintaining a healthy mouth, which includes not only teeth, but the lips, gums and supporting tissue. This involves activities such as brushing teeth and oral appliances and maintaining oral mucosa. SOM Appendix PP at F677.

Communication includes “speech, language and other functional communication systems.” 42 CFR §483.24(b)(5). These refer to a resident’s ability to effectively communicate requests, needs, opinions and urgent problems; to express emotion, to listen to others and to participate in social conversation whether in speech, writing, gesture, behavior, or a combination of these, such as a communications board or electronic augmentative communication device. SOM Appendix PP at F677.
Assistance with the bathroom refers to a resident’s ability to use the toilet room (or commode, bedpan, urinal); transfer on/off the toilet, clean themselves, change absorbent pads or Briefs, manage ostomy or catheter, and adjust clothes. SOM Appendix PP at F677.

Transfer refers to a resident’s ability to move to or from a standing position or to move between surfaces, such as to or from a bed, chair or wheelchair. SOM Appendix PP at F677.

Many other standards address personal care requirements. For example, nursing homes must:

- Provide care to maintain clean, dry skin and to prevent bedsores. 22 CCR §72315(f)(5), HSC §1599.1(b).
- Change soiled linens, clothing and other items so that residents’ skin is free from urine and feces. 22 CCR §72315(f)(6).
- Provide needed personal care services including bathing, shampooing and grooming of hair, oral hygiene, shaving or beard trimming, and cleaning and cutting of fingernails and toenails. 22 CCR §72315(d).
- Ensure that residents are free of offensive odors. 22 CCR §72315(d).
- Answer call signals promptly. 22 CCR §72315(m).
- Ensure privacy during treatments and personal care. 22 CCR §72315(l).

**Physician Services**

By law, each nursing home resident has a right to choose a personal attending physician to manage his or her medical care at the facility. 42 USC §1396r(c)(1)(A)(i), 42 CFR §483.10(d), 22 CCR §§72303 & 72307. A facility may not interfere in the way a resident chooses his or her physician. If a resident does not have a physician, or if the resident’s physician becomes unable or unwilling to continue providing care to the resident, facility staff must assist the resident or the resident’s representative in finding a replacement. SOM Appendix PP at F555.

Notwithstanding this important right, most residents do not have a doctor willing or available to serve as their attending physician and end up being assigned to a doctor who is already seeing other residents at the facility. It is worth every effort to seek an attending physician who will put the resident’s interests above that of the facility.

The facility must ensure that each resident remains informed of the name, specialty and way of contacting the physician and other primary care professionals responsible for his or her care. 42 CFR §483.10(d)(3).

Each resident must remain under the care of an attending physician who supervises his or her care. 42 CFR §483.30(a). At the time each resident is admitted, the facility must have physician orders for the resident’s immediate care. 42 CFR §483.20(a).

The role of attending physicians is much broader than their often-limited presence in nursing homes seems to suggest. They are responsible for reviewing the resident’s total program of care at each required visit; writing, signing and dating progress notes during visits; issuing care and treatment orders; participating in the resident’s assessment and care planning; monitoring changes in the resident’s medical status; and providing consultation or treatment when contacted by the facility. Their duties also include prescribing medications and therapy, ordering a resident’s transfer to the hospital, conducting required routine visits or delegating to and supervising follow-up visits by non-physician practitioners. 42 CFR §483.30(b), SOM Appendix PP at F710, 22 CCR §72303.

Physicians generally must see and evaluate residents at least every 30 days and more often if needed. 42 CFR §483.30(c), 22 CCR §72307(a). Some visits and tasks may be delegated to a physician assistant, nurse
practitioner, or clinical nurse specialist who is under the supervision of the physician, to the extent permitted by California law. 42 CFR §483.30(e), 22 CCR §72303(c).

Nursing homes must carry out doctors’ orders and arrange all necessary diagnostic and therapeutic services recommended by the resident’s physician, podiatrist, dentist or clinical psychologist. 22 CCR §72301(d)&(f). If the services cannot be brought into the facility, the nursing home must help the resident arrange transportation to and from the service location. 22 CCR §72301(d).

Nursing homes are required to notify the resident’s attending physician promptly of: (1) a sudden or marked adverse change in signs, symptoms or behavior; (2) an unusual occurrence involving the resident; (3) a change in weight of five pounds or more within a 30 day period; (4) an untoward response to a medication or treatment; (5) a life threatening medication or treatment error; or (6) a threat to a resident’s health or safety caused by the facility’s inability to timely obtain or administer prescribed drugs, equipment, supplies or services. 22 CCR §72311(a)(3).

They must also notify the resident’s physician and representative, if any, when any of the following occur: an accident involving the resident results in injury and has the potential for requiring physician intervention; a significant change in the resident’s physical, mental or psychosocial status; a need to alter treatment significantly; or of a decision to transfer or discharge the resident from the facility. 42 CFR §483.10(g)(14).

Nursing homes must have substitute doctors available to provide supervision and emergency medical care whenever residents’ attending physicians are unavailable. 42 CFR §483.30(a)&(d), 22 CCR §72301(g).

**Pressure Sores**

People who lie or sit in one position for long periods are at risk of developing pressure sores, also known as bedsores, pressure ulcers or decubitus ulcers. They occur when pressure on the skin shuts off blood vessels, depriving skin tissue of oxygen and nutrients. If proper care is not given, large, deep sores can develop, sometimes exposing the muscle or bone below the skin. Untreated pressure sores can lead to infection, severe pain and death.

Generally, pressure sores can be prevented with proper care. Nursing homes are required to provide care to prevent residents who do not have pressure sores from developing them and, for residents who have pressure sores, to provide necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. 42 CFR §483.25(b), HSC §1599.1(b).

To prevent pressure sores, nursing homes must keep a resident’s skin clean and dry, maintain good nutrition and keep pressure off of vulnerable parts of the body. Pressure is relieved by changing a resident’s position as often as necessary and using pressure relieving devices, such as pads and special mattresses. Repositioning is critical for residents who are immobile or dependent upon staff for repositioning, as they are unable to make small movements on their own that would help to relieve prolonged pressure to one area. 22 CCR §72315(f), HSC §1599.1(b), SOM Appendix PP at F686.

Studies show that pressure sores tend to develop soon after admission to a nursing home. Residents should be assessed upon admission for risk factors for developing a pressure sore. SOM Appendix PP at F686, 42 CFR §483.20, 22 CCR §72311(a)(1)(A).

A nursing home must notify a resident’s physician immediately if he or she develops a pressure sore and must follow the doctor’s treatment orders to clean and dress the wound. It is vital to relieve pressure from the wound and ensure that the resident receives proper nutrition and hydration. If the treatment is not effective, the nursing home must again notify the resident’s physician. 22 CCR §72315(f)(7), SOM Appendix PP at F686.
Quality of Life

While some may not consider quality of life a care standard, it is unquestionably vital to each resident’s wellbeing. Accordingly, the federal Nursing Home Reform Act of 1987 treats quality of life as a cornerstone requirement for nursing homes. It states: “A nursing facility must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident.” 42 USC §1396r(b)(1)(A).

Additionally, federal regulations declare that “quality of life is a fundamental principle that applies to all care and services provided to facility residents.” 42 CFR §483.24. The essence of this standard is that nursing homes must tend to the human spirit as carefully as to physical and medical needs of residents.

The intent of the Quality of Life standard is for nursing homes to create and sustain an environment that humanizes and individualizes each resident’s quality of life by:

- Ensuring all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident; and
- Ensuring that the care and services provided are person-centered, and honor and support each resident’s preferences, choices, values and beliefs. SOM Appendix PP at F675.

Quality of life standards are woven throughout federal and California laws. For example, nursing homes are required to:

- Treat each resident with respect and dignity, recognize each resident’s individuality and protect and promote the rights of the resident. 42 CFR §483.10(a)(1).
- Promote and facilitate resident self-determination through support of resident choice. 42 CFR §483.10(f).
- Reasonably accommodate resident needs and preferences in the provision of care and services 42 CFR §483.10(e)(3).
- Provide activities designed to meet the interests of and support the physical, mental, and psychosocial wellbeing of each resident, encouraging both independence and interaction in the community. 42 CFR §483.24(c)(1), HSC §1599.1(d).
- Offer a safe, clean and comfortable environment, allowing residents to use personal belongings to the extent possible. 42 CFR §483.10(i)(1).

Many other rights support a resident’s right to quality of life. For a detailed summary of residents’ rights in California nursing homes, see CANHR’s Fact Sheet, Outline of Nursing Home Residents’ Rights.

Refusing Care

Residents have the right to choose or refuse any care or treatment offered, at any time and for any reason. 42 CFR §483.10(c)(6), 22 CCR §72527(a)(4) & 72528.

The nursing home and residents’ physicians must inform them in advance about care and treatment they are planning and seek their informed consent. 42 USC §1396r(c)(1)(A)(i), 42 CFR §483.10(c)(5), HSC §1418.9, 22 CCR §72527(a)(3)&(5), 22 CCR §72528. This means they must give residents pertinent information about treatment options and the possible benefits and consequences. Residents and their representative have the final say in decisions about accepting or refusing proposed treatment and care.
Residents should not be neglected or evicted if they refuse care or treatment. A nursing home is obligated to identify and present alternative care approaches that address resident goals and concerns. SOM Appendix PP at F578, F626 and F656.

**Respiratory Care**

The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident’s goals and preferences. 42 CFR §483.25(i).

When respiratory therapy services are required in the resident’s comprehensive plan of care, a facility must either provide the required services or obtain them from a qualified provider. 42 CFR §483.65(a). Qualified professionals such as respiratory therapists and respiratory nurses shall provide needed respiratory therapy services to assess, treat, and monitor residents with deficiencies or abnormalities of pulmonary function. SOM Appendix PP at F695. These services are considered a facility service provided to all residents who need them based on their comprehensive plan of care and are included within the scope of facility services. SOM Appendix PP at F825.

Specialized respiratory therapy services must be provided under the written order of a physician by qualified personnel. 42 CFR §483.65(b).

**Safety and Preventing Accidents**

One of the most fundamental rights of nursing home residents is to safety. Each resident is to be provided a safe, clean, comfortable and homelike environment. 42 CFR §483.10(i), 42 USC §1396r(d)(3), 22 CCR §72637(a). Nursing homes must ensure that the resident receives care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. 42 CFR §483.10(i)(1)(i).

This section addresses standards related to prevention of accidents and to a nursing home’s duty to provide adequate supervision to keep residents safe.

Falls and accidents are a most common concern for nursing home residents. About half of residents fall annually, often resulting in serious or life-threatening injuries. Facilities must implement comprehensive, resident-centered fall prevention plans for each resident at risk for falls or with a history of falls and review and update them when falls occur. SOM Appendix PP at F689.

In addition to falls, there are many other potential threats to a nursing home resident’s safety, such as elopement, hazardous conditions, unsafe equipment, altercations with other residents, and hazardous water temperatures, to name just a few of them.

Elopement is a situation in which a resident leaves the premises or a safe area without the facility’s knowledge and supervision, if necessary. It places residents at risk of harm from heat or cold exposure, dehydration, other medical complications, drowning and being struck by an automobile. SOM Appendix PP at F689.

Federal standards require nursing homes to keep the resident environment as free of accident hazards as is possible and to ensure that each resident receives adequate supervision and assistive devices to prevent accidents. 42 CFR §483.25(d).

The lack of adequate supervision is often the root cause of resident accidents and injuries. Adequate supervision is determined by assessing the appropriate level and number of staff required, the competency
and training of the staff, and the frequency of supervision needed. This determination is based on the individual resident’s assessed needs and identified hazards in the resident environment. Adequate supervision may vary from resident to resident and from time to time for the same resident. 42 CFR §483.25(d)(2), SOM Appendix PP at F689.

Therapy Services and Mobility Care

Therapy Services: Nursing home residents often need specialized rehabilitative services – more commonly known as therapy services – to restore or maintain abilities affected by strokes, broken bones and other conditions.

A nursing home must provide, or arrange to be provided, therapy services to each resident who needs them. Federal law requires that therapy services be provided to a resident when needed “to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing.” 42 USC §1396r(b)(4)(A)(i), 42 CFR §483.65.

The intent of this regulation “is to ensure that every resident receives specialized rehabilitative services as determined by their comprehensive plan of care to assist them to attain, maintain or restore their highest practicable level of physical, mental, functional and psycho-social wellbeing.” SOM Appendix PP at F825.

“Specialized rehabilitative services” are “specialized” in that they are provided based on each resident’s individual assessed rehabilitative needs based on their comprehensive plan of care and can only be performed by or under the supervision of qualified personnel. SOM Appendix PP at F825.

The range of therapy services to be provided is equally broad. Therapy services include, but are not limited to, physical therapy, occupational therapy, speech–language pathology, respiratory therapy, and rehabilitative services for a mental disorder and intellectual disability. 42 CFR §483.65(a).

Therapy services must be provided under the written order of a physician by qualified personnel. 42 CFR §483.65(b). “Qualified personnel” means a physical therapist, occupational therapist, respiratory therapist, speech–language pathologist, physician, nurse practitioner, clinical nurse specialist, or physician’s assistant who is licensed or certified by the state to furnish therapy services. Qualified personnel may also include a physical therapist assistant (PTA), or an occupational assistant (OTA) when furnishing services under the supervision of a qualified therapist. SOM Appendix PP at F826.

Therapy services during Medicare covered stays: Medicare covers skilled therapy services during a covered stay in a certified skilled nursing facility, however, coverage for these services is often improperly cut short by decisions that a resident is not improving or has reached a plateau. The “improvement standard,” as it is known, is not a legal basis for denying Medicare coverage of therapy services. Medicare regulations state: “The restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities. 42 CFR §409.32(c).

In 2013, Medicare beneficiaries settled a class action lawsuit, Jimmo v. Sebelius, against the federal government challenging use of the improvement standard. In 2017, a federal judge issued a corrective action plan requiring CMS to post information about Jimmo on its website, which can be found here: An Important Message About the Jimmo Settlement. The Center for Medicare Advocacy, which is lead counsel for the Medicare beneficiaries in the Jimmo case, has posted extensive information on the Jimmo ruling on its website, including a toolkit on Medicare Skilled Nursing Coverage & Jimmo.
Therapy services during Medi-Cal covered stays: It is common, but illegal, for nursing homes to halt therapy services when a resident exhausts Medicare skilled nursing facility coverage and transitions to Medi-Cal to pay for the stay. Doing so deprives residents of essential care they are entitled to receive.

The rights of Medi-Cal recipients to receive therapy services during a nursing home stay were settled long ago. In October 1990, two California nursing home residents filed a class action lawsuit against the California Department of Health Services for failing to implement the federal Nursing Home Reform Act of 1987, contending that this failure deprived them and their class of the protections and benefits of this federal legislation. The residents largely prevailed in the case, Valdivia v. California Dept. of Health Services, leading to a court order that directly addresses Medi-Cal coverage of therapy services during a nursing home stay.

The Valdivia stipulation and order approved by the Court on April 9, 1993 requires California to “clearly articulate and consistently implement its policy that residents of nursing facilities receive needed therapy services in order to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive resident assessment and individualized plan of care.” It further provides that “the State shall take all steps necessary to process properly completed Treatment Authorization Requests (TARs) for therapy, including but not limited to, physical therapy, occupational therapy, and speech therapy, so that such therapies are approved on a timely basis necessary for the resident to attain or maintain the highest practicable physical, mental, or psychosocial functioning in accordance with the comprehensive resident assessment and individualized plan of care. This standard, which is mandated by the federal nursing home reform law, requires more comprehensive coverage of therapy services than do the standards for medical improvement that are currently contained in State law and regulation. TARs for therapy services necessary to attain or maintain the highest practicable level of physical, mental or psychosocial functioning shall not be denied on the grounds that the purpose of the therapy is to maintain the current level of functioning, rather than to improve it.” Valdivia v. California Department of Health Services, Class Action Stipulation and Order, U.S. District Court, E.D. California, Civ. No. S-90-1226 EJG PAN, April 9, 1993.

Mobility Care: Many nursing home residents need individualized care to maintain mobility and to keep the ability to move their hands, arms, legs and feet. Without proper care, residents often lose mobility or lose some ability to move their joints (range of motion) or develop contractures – a freezing of the joint in a contracted position.

Nursing homes must ensure that residents do not experience avoidable loss of range of motion by providing appropriate treatment and services to increase range of motion or to prevent decrease in range of motion. 42 CFR §483.25(c). Additionally, residents with limited mobility must receive appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. 42 CFR §483.25(c)(3).

Nursing homes must assess each resident’s mobility and range of motion to determine needed care. For those in need, care plans must include specific interventions, exercises and/or therapy to maintain or improve the range of motion and mobility, or to prevent declines in the resident’s range of motion or mobility. Care plan interventions may be delivered through the facility’s restorative program or through specialized rehabilitative services. SOM Appendix PP at F688.

Trauma-Informed Care

A nursing home must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents’ experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. 42 CFR §483.25(m), §483.21(b)(3), §483.40.
“Trauma” results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the person’s functioning and mental, physical, social, emotional or spiritual well-being. SOM Appendix PP at F699.

About seventy percent of adults in the United States have experienced some type of traumatic event at least once in their lives. Residents of long-term care facilities often include trauma survivors such as military veterans, survivors of disasters, Holocaust survivors, survivors of physical, sexual and/or mental abuse, or other violent crimes, as well as residents with a history of imprisonment, homelessness, or who have suffered the traumatic loss of a loved one. SOM Appendix PP at F699.

There is a direct correlation between trauma and physical health conditions such as diabetes, chronic obstructive pulmonary disease, heart disease, cancer and high blood pressure. SOM Appendix PP at F699.

Trauma-informed care involves understanding, recognizing and responding to the effects of all types of trauma. It is a multi-pronged approach that recognizes the widespread impact and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures and practices to avoid re-traumatization. SOM Appendix PP at F699.

Residents who are trauma survivors may have lost the ability to trust caregivers and feel safe in their environment. Thus, the following principles of trauma-informed care must be addressed and applied purposefully.

- Safety – Ensuring residents have a sense of emotional and physical safety.
- Trustworthiness and transparency – Efforts to establish a relationship based on trust, and clear and open communication between the staff and the resident.
- Peer support and mutual self-help – If practicable and appropriate, assist the resident in locating and arranging to attend support groups which are organized by qualified professionals.
- Collaboration – There is an emphasis on partnering between residents and all staff and disciplines involved in the resident’s care in developing the care plan. There is recognition that healing happens in relationships and in the meaningful sharing of power and decision-making.
- Empowerment, voice, and choice – Ensuring that resident’s choice and preferences are honored and that residents are empowered to be active participants in their care and decision-making, including recognition of, and building on resident’s strengths. SOM Appendix PP at F699.

Through its care planning process, the facility should collaborate with resident trauma survivors, and as appropriate, the resident’s family, friends, and any other health care professionals to develop and implement individualized interventions. Trauma-specific interventions generally recognize the survivor’s need to be respected, informed, connected and hopeful regarding their own recovery. SOM Appendix PP at F699.

Federal regulations and guidance put strong emphasis on cultural competence in planning and providing care to residents with histories of trauma. A key component of cultural competence is communicating with residents in languages and methods they understand, including use of translators. Staff must demonstrate proficiency in communicating with a resident to assure that critical information can be conveyed, such as a change in condition, the presence of pain, explanation of routine care, and the ability to refuse care and services. SOM Appendix PP at F699.

Facilities must create and sustain an environment that humanizes and promotes each resident’s well-being and feeling of self-worth and self-esteem. To do so, their staff must be aware of the impact of culture and cultural preferences on the provision of care and have an understanding of the cultural norms and practices of the individuals they care for. SOM Appendix PP at F699.
Care and support for trauma survivors is only as well-informed as the staff who provide it. Each nursing facility must identify the skills and competencies its staff need to work effectively with its residents who have a history of trauma and must have sufficient qualified, direct care staff to meet those residents’ needs. 42 CFR §483.40(a), SOM Appendix PP at F741.