EXPLORATION OF FACTORS IN DEVELOPING A RESOURCE HANDBOOK FOR SAN JOAQUIN COUNTY RESIDENTS IN SKILLED NURSING FACILITIES

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EXPLORATION OF FACTORS IN DEVELOPING A RESOURCE HANDBOOK FOR
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A Project

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Abstract

of

EXPLORATION OF FACTORS IN DEVELOPING A RESOURCE HANDBOOK FOR SAN JOAQUIN COUNTY RESIDENTS IN SKILLED NURSING FACILITIES

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This project was a collaborative effort in which the work and decision making was equally shared by the researchers. Resident advocacy is a role in which several facets of care are embedded. The research conducted considered the different foundational aspects of the business model, social service model and medical model in the creation of a handbook. The models typically embrace opposite philosophies, which create an adversarial environment. Research was conducted via a survey method among the 26 skilled nursing facilities located in San Joaquin County as well as 28 volunteer Ombudsman serving the same county. Of those invited to participate a total of 21 completed surveys were collected from volunteer ombudsman, 12 from Directors of Nursing, and 15 from facility administrators. By researching common themes among the three models an advocacy handbook was created that integrated each disciplines foundational philosophies in a meaningful way.

_____________________, Committee Chair
Dr. Santos Torres, Jr.

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Date

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Chapter 1

THE PROBLEM

Introduction

Mrs. B is a 69 year old Spanish speaking female who is insulin dependent diabetic and attends dialysis 3 times a week. Mrs. B stayed with various family members in the Lodi/Stockton, California area, This enabled her to retain her independence until she suffered a minor stroke and was hospitalized. Family members were encouraged by hospital social workers to consider placement in a skilled nursing facility (SNF) to assist her with rehabilitation. The family members were given names of local skilled nursing facilities to tour and select a SNF based on Mrs. B’s current medical insurance (Medi-Cal and Medicare) and location of her primary doctor. The family wanted Mrs. B to stay in Lodi were she was hospitalized but no SNF facility would admit her as she did not have a local physician that would follow her care. Mrs. B was placed in a SNF in Stockton, California, where her primary physician was located. After several months of rehabilitation in the SNF, Mrs. B developed medical complications that required acute hospital care and she was admitted to a local hospital. After being hospitalized for a few days, she was ready to be discharged from the hospital back to the SNF where she remained a resident. Unfortunately, Mrs. B and her family were informed by the admissions coordinator and the social service department at the facility that they could not readmit her because she required a higher level of care. The family did not understand what they were talking about, as Mrs. B did not require any additional medical help or extra help with her personal care needs. The family pleaded with the
SNF to accept her back as she felt comfortable being there. The family was unsuccessful in convincing the SNF to accept her back and did not know what to do next. They discussed their concerns with the hospital social worker and the discharge planner for the hospital gave them a list of SNF located within San Joaquin County to inquire if any SNF would admit Mrs. B as a new patient. They found a facility willing to take Mrs. B in the Lodi area but the SNF needed to obtain additional information on Mrs. B from her prior SNF. Unfortunately, the family was notified by the new SNF that they could not accept her. No other explanation was given to the family. The family was distraught and overwhelmed about the situation. They only wished that Mrs. B to be in a safe living environment where her needs could be met. They did not want her to go back to her prior SNF as they feared that Mrs. B would not be treated fairly since the family was advocating on her behalf and had confronted the SNF for explanations. Mrs. B’s family contacted, José Ordaz to assist them in finding a SNF and to advocate on her behalf. The family was encouraged to call the local Ombudsman to discuss their concerns. Mrs. B and her family members filed a report with the Ombudsman and state licensing as the facility was not complying with the seven-day bed hold and refusing to readmit her by not providing a formal 30-day notice of eviction. In addition, the family felt that the facility was retaliating against them as they questioned the SNF for not readmitting her and causing her additional distress. Mrs. B and her family members did not know that they had any rights under the 1987 Nursing Home Reform law.

Mr. W was an independent and virile man. The last glimpse of this individual was during Thanksgiving Dinner in November of 2008. Mr. W drove from his home, where
he lived independently to his son’s home and was a lively participant in the traditional family festivities. A week before Christmas he had a fall carrying in groceries from his car. After surgery and a few weeks recovering at the hospital, he was admitted to a skilled nursing facility that would help him to recuperate from a broken hip. He was five months shy of his eighty-seventh birthday when he died in March 2009. Mr. W was my grandfather. My grandfather was similar to all of the other grandparents now residing in skilled nursing facilities. Often they have acute episodes, which lead them to skilled nursing facilities for respite and recuperation, prior to returning home. This is typically the goal of most residents, family members and friends. However, this goal may be contradictory to the goal of skilled nursing facilities; often for profit businesses that rely on maintaining full occupancy to make a profit. From January to March, I watched in awe as my uncle and father, educated and capable individuals, suffered at the hands of facility politics, protocols, and culture. The actual events that occurred to Mrs. B and Mr. W are not uncommon stories and have led the researchers, Jose Ordaz and Renee Smith to the research development of this topic. This project will provide basic tools that families can utilize to advocate for the needs of their loved ones in a way that is beneficial to both facility and resident.

Statement of Collaboration

This project was co-authored by José A. Ordaz and Renee Smith. The researchers participated equally in all aspects of this project.
Background of the Problem

Due to the current societal expectations and demands of today’s lifestyle family members of the elderly are often geographically separated, financially dependent on two incomes, and strained in regards to time and resources. The family members that are accessible find it difficult to accept that a loved one can no longer take care of him or her self and family is unable to take care of them; in addition to discovering that current policies and resources are limited in providing support. Placement in nursing homes often involves a great deal of family stress and emotion (Shugarman and Brown, 2006). Family and friends are frequently ill at ease when they can no longer care for the needs of their elderly loved ones and struggle through the decision to turn to a nursing home for care. Many nursing home decisions are made on an urgent basis and family members may not have the time to carefully research a range of nursing homes. Nursing homes are an important module of long-term care as the growth of our elderly population augments. “There will be a rapid growth in the number of persons age 60 and over as the Baby Boomers begin turning 60 in 2006” (Aging, 2007). The U.S. Census Bureau 2005-2007 estimated the population of San Joaquin County to be 664,423. Approximately 65,347 are estimated to be 65 years of age and over with an average median of 74.9 years. Out of counties surveyed by population containing more than 10,000 people age 65 and over, San Joaquin County was ranked 112th out of 638 counties.

Stress felt by family members and residents can cause emotional turmoil. In addition to the emotional factor is the financial burden. The price of a semi-private room in a San Joaquin County skilled nursing facility is on average $68,536 per year. Those
who desire a private room will pay approximately $71,175 per year (Genworth Financial, 2009). Skilled nursing facilities, often referred to as nursing homes, are typically seen as the place furthest away from home. Due to the prohibitive cost, residents often find themselves selling their “real” homes to finance a residence they never wanted to move into.

Nursing home regulations date back to 1967 when Congress created a set of standards as part of the voluntary participation of nursing homes in the Medicare and Medicaid programs. However, the standards were weak and all but a few nursing facilities were able to meet them. Prior to the enactment of OBRA 87, quality regulations focused on nursing homes’ ability to provide care rather than the quality of care received by residents. A landmark report by the Institute of Medicine on improving the quality of care in nursing homes made recommendations to improve the procedures for inspections of skilled nursing facilities and strengthened the enforcement laws, including advocacy and community involvement (Institute of Medicine, 1986). In 1980 and again in 1987 these nursing home regulations were updated with new standards imposed under the 1987 and 1990 Omnibus Budget Reconciliation Act (OBRA 87 and OBRA 90) also known as Nursing Home Reform Act. The requirements by OBRA 87 required patient choice in health care decisions. It made each state responsible for monitoring and enforcing state licensing and federal standards. Skilled nursing facilities (SNF) were required to provide 24 hour licensed care seven days a week. On the other hand, OBRA 90 made the SNF’s provide written information on the patient’s rights under state law concerning medical care by preparing advance directives and choosing acceptance or refusal of medical
treatment. Furthermore, OBRA 87 required that SNF’s with 120 beds or more must have a social service director. The Act of 1987 also expanded the Ombudsman role. The Older American Act established the Long-Term Care Ombudsman Program in 1978 to provide advocacy to residents in any licensed care facility. OBRA 87 focused on improvement of quality of care and quality of life for elders in nursing homes (Stahlman & Kisor, 2000, Lacey, 1999). Skilled nursing facilities developed from the medical model, which emphasize a minimum quality of care with little thought and effort given to quality of life (Kane, 1996). Quality of care requirements under the Code of Federal Regulations (CFR) 483.25 state that the nursing home resident should get better whenever possible. The SNF at very least should provide the highest possible level of physical, mental and psychosocial functioning. The resident should not get worse from the care provided at the SNF unless their decline is medically unavoidable. For a long time, skilled nursing facilities and state regulatory agencies focused more on safety such as restraints. In contrast, the quality of life regulation under CFR 483.15 requires the facility to care for its residents in a manner and in an environment, which promotes maintenance or enhancement of each resident’s quality of life. In other words, reasonable accommodations need to be made for individual needs and preference. Residents have the right to make choices about daily schedules, health care and emotional well-being. Respecting resident’s individuality like home routines should be tailored to their needs instead of the residents adapting to the schedules imposed by the skilled nursing facilities. Skilled nursing facilities tend to focus on routine and the rights of the individual residents get lost in operating as a business.
More than 20 years have passed since the 1987 Nursing Home Reform Act that required across-the-board changes in federal standards to improve the quality of care in nursing homes but the problem continues as facilities phase in and out of compliance. Implementation has been slow and continued quality of care is far from being complete. Far too frequently, nursing home residents still experience poor care and neglect. Family involvement can improve life for nursing home resident’s one person at a time. As we face changes in our health care system one can make sure those improvements benefit the nursing home residents. It is important to think about what you would want if you were in a SNF to understand what the residents are feeling. Residents cannot fully depend on the surveyors or inspectors who monitor skilled nursing facilities as they only see a snapshot of daily life when they are there. Historically, serious complaints by residents remain uninvestigated for weeks or months, and delays in reporting of abuse allegations compromised the quality of available evidence, hindering investigations (U.S. GAO, 2005). Consumer advocates such as family, friends or legal representatives play an important role in advocating for good quality care. Residents need support and encouragement to exercise their rights.

Statement of the Research Problem

Currently patient advocacy for long-term care residents relies on the action of family members, long term care ombudsman, and facility staff. The method has been lacking in ensuring quality of life, safety and quality of care for many residents. The future holds a host of issues and concerns for the skilled nursing industry. Expectations regarding the level of care concerning physical, emotional and psychosocial aspects will
change based on the differing aspects of each generation. “Generation X” those born between the year 1965 and 1979 are computer savvy (Rosenberg, 2009). This particular generation has been educated, entertained, and impacted by worldwide culture in the comfort of their own homes. Baby boomers, those born between 1946 and 1964 are a population that has been involved in a quality of life very different from previous generations and those generations, which follow them; they enjoy an increased amount of independence, a large knowledge base due to the accessibility of information, longevity, and improved physical health (Rosenberg, 2009). These generations have utilized technology to become informed consumers in every aspect. They will demand better quality of care as referenced earlier including quality of life. The study will explore the various quality of life factors faced by family members, facility staff and current residents in skilled nursing facilities in San Joaquin County. These factors will vary based on changing demands and shifting expectations of current and future generations. Shifts in expectations influence not only the facility resident population but also the facility staff and family members. San Joaquin County currently has no collaborative approach in dealing with complaints regarding quality of life concerns experienced by residents. The lack of collaboration to resolve quality of life issues between residents, family members, and facility staff creates an adversarial atmosphere in which no one’s needs are met. The data gathered in this study will assist in the creation of a resource handbook for families. The handbook will utilize the strengths of each discipline including nursing, business, and social work to create an effective advocacy tool. The handbook will include a
collaborative approach that is beneficial not only to the resident as well as advantageous to nursing staff and business managers.

*Purpose of the Study*

The purpose of this project is to explore the various factors that are faced by family members and current elderly residents in skilled nursing facilities in San Joaquin County. The identified factors will facilitate in the development of a resource handbook for family advocacy. “There will be a rapid growth in the number of persons age 60 and over as the Baby Boomers begin turning 60 in 2006” (Aging, 2007). The estimated population of San Joaquin County from the U.S. Census Bureau 2005-2007 American Community Survey is 664,423. 65,347 were 65 years of age and over with a medium age of 74.9 years. As of 2005, San Joaquin County was ranked 112 out of 638 counties by population aged 65 and over by the US Census with counties with 10,000 or more people aged 65 and over.

To date San Joaquin County skilled nursing facilities have 2,801 resident beds. In the last fiscal year, FY 07-08 the San Joaquin County Ombudsman program received 798 complaints. The current advocacy programs are inundated with requests for services and financial support for these programs is steadily vanishing. This study will utilize the information gathered to lessen the gap between the need for formal advocacy and the ability of families to effectively advocate for their loved ones. It will consider the emotional aspect of loved ones in comparison with the business aspect of facilities.
Theoretical Framework

Systems theory is the theoretical framework of this project. The theory was chosen for numerous reasons. Systems theory is essential when considering the many systems involved in advocacy and skilled nursing residency. The systems encompassing the resident often have different goals and views on care decisions, which lead to frequent conflict. Consider the systems involved in the daily care of residents. Residents are a system in themselves, family members, facility staff, the business aspect of long-term care, Medicaid, Medicare, and private insurance each are involved in the care of residents. The goals of each are specific to the systems they represent. These systems often have competing interests. Some of the foci of the systems include the financial aspect of care, the biomedical, psychosocial, or in combination. This project has been undertaken due to these competing goals and conflicts. Collaboration among these systems committed to the care of skilled nursing home residents is imperative. Changes within any of the related systems create a domino effect affecting the lives and well-beings of a vulnerable population that social workers are devoted to protecting. It is imperative that the collaboration among these systems be committed to the individuals that reside in skilled nursing homes. By creating a handbook that families can utilize to effectively advocate on their behalf, the quality of life will improve among this population.

This handbook will reflect an integrated approach that includes research and information related to business, communication patterns, nursing, related laws, family relationship dynamics, and social work. A strength-based model will be the basis of this
project. By demonstrating, the positive factors found in each of the systems the goal of providing and maintaining an increased quality of life amongst the elderly will be obtainable. The tools produced for this project will enable family members to collaborate effectively with other systems involved to provide desired outcomes that are viewed as a win-win situation for all.

Definition of Terms

Family Group

Family is defined by the NASW Commission on Families as “two or more people who consider themselves family and who assume obligations, functions and responsibilities generally essential to healthy family life.” (Barker, 2003) In the nursing home, family groups are those members who meet together with faculty staff to discuss issues relating to the residents.

Long-term Care (LTC)

Barker (2003) states that LTC is a “system of care providing social, personal and health care services over a sustained period to people who in some way suffer from functional impairment, including a limited ability to perform activities of daily living (ADL)” (p. 253). Nursing homes are one type of agency that provides these services. The Nursing Home Reform Law of the Omnibus Budget Reconciliation Act, PL 100-2003 (OBRA 87)

The Nursing home Reform Law of the Omnibus Budget Reconciliation Act (PL 100-2033) is also referred to as OBRA 87 and is a vital legislation and is defined by Stahlman and Kisor (2000):
The Foundation of OBRA 87 is improving quality of care and quality of life for older persons in institutional settings. Important provisions include expanding resident’s rights; improving resident assessment and care planning; reducing the use of chemical and physical restraints; and upgrading training and licensing of personnel (Stahlman & Kisor, 2000, p. 226).

Department of Nursing (D.O.N.)

The term D.O.N. is used within facilities to indicate the head of the nursing department.

Quality of Care

The Omnibus Budget Reconciliation Act (1987) views quality of care as factors relating to medical, psychological, and social needs. The legislation specifies many indicators which reflect different aspects of the resident’s daily life in the nursing home (Stahlman & Kisor, 2000).

Quality of Life

Quality of life is defined as “…care that maintains or enhances dignity; the provision of social services to attain the highest practicable well-being of each resident; and a safe, clean, comfortable and homelike environment” (Department of Health & Human Services).

Skilled Nursing Facilities (SNFs)

According to Barker (2003), SNFs are facilities for patients who usually require long-term care (LTC). They are staffed by highly skilled professional nursing staff.
Assumptions

The first three assumptions made relate to the disciplines surveyed. Foundational differences between the disciplines create much of the conflict within facilities in relation to advocacy. Each discipline is concerned about the health of particular areas. The core foundation of SNF administrators is the financial health of the business. The nursing discipline has a foundation directed towards the physical health of patients. The social work discipline has a foundation grounded in the psychosocial or emotional well being of patients. Assumptions regarding residency within a facility are also noted. Residents of long-term care once admitted become a disease, a fall risk, or a bed number. Assumptions such as these are deeply ingrained not only in the minds of staff but of family members and residents alike. Institutionalization changes the things that make us who we are in our lives including our relationships. Resident’s grandchildren cannot stay the night in a facility; residents do not go on vacation, dates, or cook a meal for family members. These tasks of daily living and reciprocal relationships are stripped from residents the moment they enter the facility as a patient. It is assumed that residents no longer have a need for continued intimacy, activity, or reciprocal relationships. One assumes that at a certain age that we just stop being human beings. Elders in nursing homes are a vulnerable population who seek self-determination and an opportunity to shape their environment. Elders continue to desire all of the connections that they previously had. The difference is that these connections are often more difficult to maintain once admitted to a SNF. Additionally, it is implied that when an elder is admitted to a SNF that they are unable to continue with daily schedules and activities. It is assumed that elders cannot have their
belongings around them to provide comfort and a home like environment. It is assumed that family members are not allowed to visit outside of specified visitation hours, bring beloved pets into the facility, have elders visit outside of the facility or to plan special events and celebrations important to the resident. Further, it is assumed that residents in skilled nursing facilities want a higher quality of life and consumer satisfaction.

**Justification**

As noted above San Joaquin County was ranked 112 out of 638 just four years ago in regards to its population aged 65 or older. Statistics reveal that this population is in only the beginning stages of a population explosion. Due to current political and economic atmospheres the coming years will likely see a reduction in Ombudsman related services. We can reasonably assume that increases in the aging population will likely lead to increases in residency rates of skilled nursing facilities. Therefore, complaints regarding care involved in skilled nursing facilities will also increase. The ability of family members to effectively coordinate, negotiate, and advocate for their loved ones will be instrumental in ensuring quality of life in the skilled nursing facility setting. Currently there is no clear collaborative approach to advocate for residents, there is a documented lack of expertise in social work regarding gerontology, and 20 years after the passing of OBRA 87 there remains significant concerns in quality of life care (U.S. GAO, 2005). This resource handbook will reduce the current gap of knowledge in this area and provide a tangible process to all concerned to provide advocacy for one of our most vulnerable populations.
Limitations

The project may not be generalized due to the specific characteristics of San Joaquin County. A convenience sampling method was utilized. The county is largely a farming community with areas of high crime, poverty, and low educational levels. The researchers focused solely on elderly residents. Based on this factor, the research is inadequate in identifying variables as they may relate to specific advocacy needs of residents with mental health diagnosis or developmental delays as their primary reason for admission to a SNF. The researchers determined that anonymity to all research participants would have been preferred. However, the researchers chose to provide and collect the questionnaires in person in an attempt to ensure return results. Confidentiality was assured to all participants. However, given the well documented pressure applied to staff members within SNF’s, participants may or may not have felt pressure to give the “right” answer based on the subject matter and its reflection on the facility. It was determined that both the facility administrator as well as the nursing department head (D.O.N) are in a position’s of power within the facility and would be most likely to implement new policy changes. Therefore, both parties were provided with a survey and asked to complete and return it. The research did not include data collection from SNF residents. Data was not collected from family members due the probability of high emotion skewing data.
Chapter 2

REVIEW OF LITERATURE

Introduction

A review of the literature related to this topic is necessary to determine what systems have an impact in decision-making and advocacy within SNF’s. The three main disciplines chosen for review were business, nursing and social work. The three disciplines are imperative in providing quality of life for residents within skilled nursing facilities. Each of the disciplines has a role within patient advocacy yet their perspectives vary greatly, leading to an ineffective and adversarial advocacy approach. Residents, facility staff, and family members deserve to have a method in which to advocate for the quality of life for nursing home residents. Applicable laws, regulations and health care insurance issues were included to clarify the information as often these issues are intertwined in the need for advocacy. As noted above the literature reviewed for this project did not rely solely on social work literature.

The researchers determined that a triangulation of data must occur in order to create the most effective tool for families. The three disciplines researched were business, nursing and social work. These disciplines create the foundation of skilled nursing home residency. Due to the differences among these disciplines, family members have been unable to have clear and consistent means in which to advocate effectively for their loved ones. The differences have led to poor communication and advocacy, which has left families feeling angry and cheated and facilities defensive, and on the front page of the newspaper. This literature review will allow for an in depth look at each discipline in
order to extract similar characteristics. The characteristics will be delineated to identify an advocacy approach that will effectively utilize the group dynamics likely to occur in a skilled nursing home setting. The business model, medical model, and psychosocial models are quite different. Each discipline communicates differently, has different goals, expectations, conflicts, value systems and constraints. This section will incorporate applicable legal and regulatory aspects of skilled nursing home care, communication patterns, group dynamics, and statistics. All of the research will be included to create the most inclusive advocacy handbook to date.

Business

The business model is the foundation of many nursing homes. Business models rely on “bottom line” figures and their goal is to make a profit. Profits are made by lowering the “cost of doing business”. Family members often see this as a negative aspect but in reality the United States has been founded on the idea of free enterprise, competition, and the American Dream. Businesses strive to maintain their profit margins or run the risk of going out of business. This is one of the most important aspects to consider. Skilled nursing homes are a business; they are in fact a very lucrative business. Administrators are not uncaring individuals and should not be seen as such. They have the responsibility to provide a quality service for the least amount of money (Nelson, 2000). Business models must engage in the improved paradigm in which skilled nursing home residents and their families are not only consumers of their product but partners as well. Often customer feedback is not voiced unless there is a problem, consumers will then tell friends, family and anyone who will listen their horror stories regarding long-
term care (McKay, 2009). The future consumers of skilled nursing home care are computer savvy, questioning, and can threaten the reputation of a facility with only a few keystrokes on the computer. Consumers that can yield this amount of power this quickly were termed in one article as “social consumers” (Greenberg, 2009).

Skilled nursing home administrators can make or break a facility by choosing where and how money is spent and the resources it will provide. Administrators must shift their thinking from crisis management to long-term improvement that will fully allow their staff to collaborate as a team in an effort to provide successful outcomes in regards to quality of life and more acceptable business practice (Castle, 2009). Skilled nursing facilities must shift their thinking to include and profit from the real experts, family members. If skilled nursing facilities do not consider other models in regards to business operations then administrators must be aware that respect for the rights of residents sometimes gets lost in the day-to-day operations of running an efficient business.

A shift in organizational leadership will allow for a more holistic approach to long-term care that includes input from not only facility staff but also residents and their loved ones as well. Currently “win-lose conflict is more likely in the nursing home more than in other settings” (Nelson, 2000, p. 9). An improvement in advocacy for residents would have a positive impact on the business arena. Skilled nursing homes spend upwards of $300,000 to $500,000 dollars per year on staff turnover alone; in part, this turnover is related to a lack of collaboration within a facility (CLTC, 2009). Staff within facilities often feel as though their input is not considered nor desired by management.
By creating a more collaborative approach that utilizes the expertise of all family and staff members this turnover rate may be significantly reduced thereby improving quality and lowering costs.

**Nursing**

Nursing is another aspect of care that must be included in this data collection. Nursing is categorized in two separate classifications within a skilled nursing home. Nurses should not be confused with Certified Nursing Assistants or C.N.A.’s, who are responsible for the personal care of residents. C.N.A’s provide the non-medical care to residents and are likely to be better known to family members. Even though these staff members have the most applicable information in relation to resident advocacy and care, they are the least likely to be included in care plan conferences. C.N.A’s are usually required by SNF’s to care for more residents than they can serve. California requires SNF’s to provide a minimum of 3.2 hours of nursing care per resident per day. The California Department of Public Health (DPH) recently passed and completed an emergency proposal (DPH-03-010E) addressing nursing staff to patient ratios. The SNF’s must post a daily census in a location available by the public addressing patient specific staff assignments for each shift. It is important to note that the Code of Federal Regulations currently requires facilities certified to participate in the Medicare and Medi-Cal Programs to post resident census and the total number and actual hours worked by licensed nurses and certified nurse aides (42 CFR 483.30(e)). As with other nursing counterparts, they also have very task driven positions that relate to direct care, documentation, and rigid timelines. The research contained in the nursing discipline
presents concerns within the discipline in regards to resident advocacy and the impact of a nurse’s advocacy on employment (Bu & Jezewski, 2006). Based on a review nurses are often torn between their code of ethics that demands the protection of patient’s rights and well-being and the role expectations within their positions. Patient advocacy is not clearly defined in the nursing code of ethics. Advocates rarely have the authority to resolve issues and facility staff is often at a loss in their ability to effectively address and resolve complaints (Bu & Jezewski, 2006, Martin & Tipton, 2007, Nelson 2000).

The role of nurses is to provide the day-to-day medical care to nursing home residents. Nursing students complete a vigorous training program. Part of the training involved with nursing is patient advocacy (BU & Jezewski, 2006). However, nursing is very task driven and decisions are made based on protocol that has been proven by research and time constraints. Nurses work within very confined guidelines that are often time sensitive. Medications must be passed within particular timelines. Documentation is a tremendous undertaking for nurses particularly regarding Medicare and Medi-Caid requirements; this documentation also has strict timeframes attached. Within skilled nursing facilities, nurses are viewed as decision makers. Since administrators may have no medical background as well as other staff, nurses are elevated to similar status that medical doctors have within hospitals. While using this medical model we must keep in mind that in a medical setting each department acts independently of the others (Hayes, 2004). The systems often function with no regard to the other systems within the hospital. A skilled nursing facility cannot operate effectively in this manner partially due to each of the departments being interconnected to the other. A shift in thinking on the part of
nursing staff will need to occur to enable nurses to shed responsibilities in which they did not request nor are trained for (Hayes, 2004).

*Social Work*

Theoretically, a social worker’s role in a skilled nursing facility would be to conduct psychosocial assessments, provide counseling services, staff with medical doctors in regards to psychotropic medications, and to address end of life concerns. This list is not all-inclusive but does provide a foundation. Unfortunately, untrained and undertrained social service providers lead American nursing homes. Social Workers or social service providers in skilled nursing facilities have minimal or no educational training background in gerontology (Scharlach et. al., 2000). In the United States, persons not specifically educated in social work may fill nursing home social work positions. The reality of social work in long-term care is often a cornucopia of tasks relegated by other staff members who do not have time to complete them. Looking for missing items, shopping for residents, and labeling laundry are to name but a few. As with many other staff members in skilled nursing time is limited to complete all of tasks deemed within the role of social work. Social workers also feel the pressure of these limitations and “As many as 45% of social workers indicated that they encountered barriers to providing psychosocial services” (NASW, 2009). One of the most prominent barriers facing social workers are regulations which dictate that a facility is not required to have a trained full-time social worker unless the facility contains 120 beds or more (OBRA 87). This often finds social workers in a world void of the social work perspective and surrounded by only business and nursing perspectives. Quality of life
deficiencies were one of the most commonly cited in the past three years (DHHS, 2008). Social workers trained in how to effectively support the psychosocial health of residents rarely have the time or are allotted the freedom to do so. One area that social workers are often called upon is to mediate conflict between staff and family members. Although nursing staff often perceive family members as meddlesome, social workers are aware that their involvement is critical to improved quality of life outcomes (Choi, 1996). Social workers whose own training calls for flexibility and creativity are often confined to a health-business model which is very rigid and goes against the very core of important social work values (Allen, 2007). As with the nursing profession, social workers are often hesitant to call on Ombudsman for fear of losing their positions within the facility (Allen, 2007). Social workers must aggressively advocate for family inclusion when addressing quality of life care within skilled nursing facilities. They too may find this a difficult challenge due to social workers have not yet been able to advocate completely for their own appropriate roles within facility structure.

Communication/Conflict

Communication appears to be a long-standing issue between facility staff, and family members (Martin & Tipton, 2007). The researchers were able to find only one study that detailed concrete steps for facility staff to follow in order to provide effective advocacy, unfortunately the study was based in Sweden and may not be generalized to the United States (Anderberg, P et. al., 2007). Communication styles vary greatly amongst the three disciplines. The traditional business model typically has a “top down” style of communication. Top managers determine what if anything should be
disseminated to staff and the information flows downward to the appropriate level.

Nursing or medical models rely on quick change of shift reports. These quick reports are typically a quick method in which nurses coming on at each shift are briefed on the status and any changes of condition in the last eight to twelve hour shift. Social workers utilize a more collaborative approach. Communication, although not always free flowing, is shared mutually between colleagues and clients in an attempt to find best possible solutions. Differences in communication styles are not the only barriers to collaboration and advocacy. Each discipline will need to acquire skills that include active listening, questioning of residents wishes and follow through to be effective (Martin, 2007). By communicating effectively with family members we can create positive feedback loops in which family members will continue to provide valuable information and staff will continue to want to interact to obtain the information (Utley-Smith, 2009). The need for honest communication between not only these disciplines but family members as well is paramount to “reciprocal understanding” and effective advocacy (Safford, 1989, p. 3).

Employees must be trained on how to effectively communicate with family members in order to alleviate a constant barrage of complaints (Brownlee, 2006). Consistent communication can encourage more effective care by keeping staff updated on changes needs and wishes of residents.

Different types of conflict also play a part in the dysfunction of skilled nursing home communication. Relationship conflict can be simply a clash in personality (Robbins, 2003). Relationship conflict can impede the progress of task completion within a facility. Diversity among goals is another aspect of conflict; this aspect is clearly
seen in relation to the differing goals among the business, nursing, and social work perspectives within a facility. Not all conflict is negative and it can lead to very useful results. Groupthink is a term coined that refers to the lack of options and rigidity in choices “Conflict is an antidote for groupthink” (Robbins, 2003, p. 405). Family members utilizing conflict can create family councils, which address common issues amongst other family members. These councils are not particularly common in SNF’s and “of the more than 15, 000 nursing facilities in the nation, less than half have family councils” (Persson, 2008, p.53).

_Regulations/Law_

The physical and cognitive conditions of the residents in SNF’s often prevent them from self-advocating and depend on laws that are in place to protect them. To illustrate this point, in 1997 the Department of Health Services (DHS) developed a standardized admission agreement for all SNF’s or Long Term Care Facilities (LTCF) to be used as a model but was stalled by the SNF’s until July of 2005. The final agreement was published and took effect on January 1, 2006. One of the regulations specifically prohibited the SNF from presenting arbitration agreements as part of the standard admission agreement. To prevent residents from being able to sue for abuse or neglect, many nursing homes still asked new and current residents to sign admission agreements that include binding arbitration provisions. It is not wise to sign such an agreement. By signing a binding arbitration agreement, you give up your constitutional right to go to court if a dispute arises in the facility, even if it involves abuse and neglect. There is no right to appeal a decision made through binding arbitration. Residents and their legal
representatives can rescind an arbitration agreement by giving written notice to the facility within 30 days of their signature. Residents and families generally receive a copy of a SNF policy on residents’ rights upon admission. The SNF has a responsibility to make sure that staff is aware of resident’s rights.

In 1980 and again in 1987 nursing home regulations were updated with new standards imposed under the 1987 and 1990 Omnibus Budget Reconciliation Act (OBRA 87 and OBRA 90) also known as Nursing Home Reform Act. The requirements imposed by OBRA 87-mandated patient choice in health care decisions. OBRA required that SNF’s with 120 beds or more must have a social service director. OBRA 87 focused on improvement of quality of care and quality of life for elders in nursing homes (Stahlman & Kisor, 2000, Lacey, 1999). The quality of life regulation under CFR 483.15 requires the facility care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident’s quality of life. Residents have the right to make choices about daily schedules, health care and emotional well-being. Respecting resident’s individuality like home routines should be tailored to meet resident’s needs instead of the residents adapting to the schedules imposed by the skilled nursing facilities. Implementation of the 1987 Nursing Home Reform Act has been slow and continuous yet realization of quality of care is far from complete. However, in October 2011 a new version of the Minimum Data Set (MDS) assessment tool is scheduled to be fully implemented and in practice. Any facility receiving federal funds through Medicaid or Medicare are mandated to utilize MDS, an assessment tool that includes various aspects of patient care, including quality of life concerns. The new tool
brings an exciting change to assessing residents in skilled nursing facilities as it draws clear attention to quality of life concerns.

*Medicare*

Health care for the elderly is one of the biggest expenditures in the United States budget. We spend one third of all national health care expenditures on people over the age of 65. This totals more than $200 billion dollars in expenditures on Medicare alone yearly, and the number is growing (Atherly, 2004). Since America's population is growing older, we are going to spend more money on programs such as Medicare, and that spending has risen fast and it presents government policymakers with a serious problem of cost control.

The Medicare program was created in 1965 as part of the Social Security Act. Before 1965, half of the aged population was without health insurance, while today almost all are covered. The goal of Medicare is equity and effectiveness in the delivery of health care for almost 40 million of aged and disables Americans. Medicare is a health program funded by the states and the federal government. Medicare pays a fee each time a beneficiary uses a service. The client is responsible for deductibles and insurance co-payments that Medicare does not pay (DiNitto, 2005).

Medicare and Medicaid are predominantly important sources of funding for nursing homes, with three-quarters of the residents dependent on one of the two programs, primarily Medicaid. Medicaid spent $53.7 billion on nursing home care and Medicare spent $21.2 billion, for a total of $74.9 billion (Kaiser Commission on Medicaid and Uninsured, 2009). The dependence of the aged on public health care
programs has changed significantly over the past half century, particularly because Medicare coverage did not exist prior to 1966. Between 1968 and 1997, the amount of health care costs covered by Medicare increased by 12 percent (DiNitto, 2005). In 2003, the Congressional Budget Office reported "the growth in national health expenditures over the 1970 to 2001 period exceeded the growth in gross domestic product by 2.5 percentage points annually." In 1960, total health expenses in the U.S. were $27 billion; in 2003, it was nearly $1.7 trillion (Atherly, 2004, p. 216). On an annual basis, these differences may seem small, but if we compound them over decades, they help explain how Medicare's share of the personal health care spending grew from 19 percent in 1970 to 37 percent in 2002.

Statistics project a major rise in the aged population compared to total population in the coming decades. People 65 and older represent 12 percent of the overall population today; they will represent 18 percent in 2025 (DiNitto, 2005). Moreover, the rise is not only the result of the post-World War II baby boom generation reaching its advanced years since "major improvements in longevity and a decline in the nation's birth rate over the past 30 years..." are projected to lead to further increases in the aged population's share of the total population after the passing of the baby boomers (Culter and Sherner, 2000, p.18). The table below illustrates this population's rapid growth:
Table 1

*Projected Rise in Aged Population*

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of aged</th>
<th>Share of total population</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>37 million</td>
<td>12%</td>
</tr>
<tr>
<td>2025</td>
<td>62 million</td>
<td>18%</td>
</tr>
<tr>
<td>2045</td>
<td>79 million</td>
<td>21%</td>
</tr>
<tr>
<td>2065</td>
<td>89 million</td>
<td>22%</td>
</tr>
<tr>
<td>2080</td>
<td>96 million</td>
<td>23%</td>
</tr>
</tbody>
</table>


For Medicare, these demographics mean a growing number of people will become eligible for coverage each year, and each following group of new enrollees will receive benefits for a longer period of their lives. For Medicare and the federal government in general this means that "a declining proportion of the population will be in the primary working age band of 20 to 65," from which much of the government's tax base comes (DiNitto, 2005, p.311). In fact, consumption of health care by the elderly is larger than for the rest of the population. In 1999, per capita health care spending for the U.S. population as a whole was $3,834. For the population under age 65, it was $2,793. For the population age 65 or older, it was $11,089, or almost four times as high. Even within the aged population, the difference was significant. For those ages 65 to 74, it was only $8,167 compared to $20,001 for those persons age 85 or older (CMS, 2004). Few seniors
are aware that their Medicare coverage will not pay for an extended nursing home stay but mistakenly most seniors still think that Medicare pays for more than it does. Medicare pays for only 100 days of nursing care for people who have recently been hospitalized. Most Medicare costs are increasing this year to keep up with the rise in health care costs.

Table 2

Medicare Coverage

<table>
<thead>
<tr>
<th>Hospital Insurance (Part A)</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>For first 60 days in a hospital, patient pays</td>
<td>$1,024</td>
<td>$1,068</td>
</tr>
<tr>
<td>For 61st through 90th days in a hospital, patient pays</td>
<td>$256 per day</td>
<td>$267 per day</td>
</tr>
<tr>
<td>Beyond 90 days in a hospital, patient pays (for up to 60 more days)</td>
<td>$512 per day</td>
<td>$534 per day</td>
</tr>
<tr>
<td>For first 20 days in a skilled nursing facility, patient pays</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>For 21st through 100th days in a skilled nursing facility, patient pays</td>
<td>$128 per day</td>
<td>$133.50 per day</td>
</tr>
</tbody>
</table>

Retrieved from [www.socialsecurity.gov](http://www.socialsecurity.gov)

Extended nursing home care can eat up your loved one’s savings quickly and many exhaust their finances after just six months. Medicaid often fills the gap for poorer Medicare beneficiaries and individuals who have spent down their assets and income in order to qualify for long-term care Medicaid coverage.
**Medicaid**

Medicaid is the federal-state program of medical assistance for certain poor and low-income people, including families with children, the elderly and the disabled. States have a broad level of flexibility to design their own program and establish eligibility standards, benefits and services covered and payment rates. All states must cover these basic services: inpatient and outpatient hospital services, laboratory and X-ray services, skilled nursing and home health services, doctor services, family planning, periodic health checkups, diagnosis and treatment of children (CMS, 2005). Long term nursing care is paid by a combination of both public (Medicare, Medicaid) and private payers. Medicaid picks up the cost of nursing home care once people have exhausted almost all of their assets. Medicaid will only pay for nursing home care that is provided at a SNF certified by the government. The income limits for Medicaid eligibility can be very low, but states can and often do set higher limits. These limits are often tied to the Supplemental Security Income (SSI) program, currently $674 per month for an individual or $1,011 for a couple in 2009 (SSI Fact Sheet, 2009). SSI is a federal program that provides monthly cash payments to people with limited incomes and resources who are age 65 or older, blind or disabled. The individuals that qualify for SSI have incomes below the federal poverty level. Medicaid is a means-tested program that provides benefits to certain people who meet the strict income and asset rules.

There are different paths to Medicaid eligibility, medically needy and benefits related. The elderly primarily become enrolled in Medicaid once they need long term nursing care or after they have spent down their income and assets. Countable assets
must fall below the SSI limits ($2,000 for an individual and $3,000 for a couple). People with assets above the Medicaid eligibility may spend down those assets and reduce them to the SSI limits. This includes checking and saving accounts, stocks, bonds and other financial assets such as individual retirement accounts. A limited number of assets are excluded from this requirement. Medicaid recipients may retain funds set aside for funeral expenses ($1,500 or less), burial spaces, life insurance policies with a combined face value of $1,500 or less, one vehicle regardless of value, the home you live in and land it is on, household goods and personal effects (SSI Resources, 2009). However, OBRA 93 allowed states to place liens on homes to recoup the cost of care from the estate of a Medicaid beneficiary once he or she has died. The property is exempt from estate recovery if: 1) the recipient's spouse is living there 2) A blind or permanently disabled child lives there or 3) If as a result of a state lien, additional protection for siblings and adult children can be satisfied. If all of these conditions cease to exist then the property becomes subject to recovery (U.S. Department of Public Health, 2005).

Medicaid applicants applying for assistance with nursing home care are subject to a look back period of five years for asset transfer. Medicaid rules seek to prevent transfers by restricting eligibility for those who make transfers at less than fair market value which eligibility may be denied. This is intended to prevent those above eligibility levels for Medicaid from giving away resources in order to quality rather than spending down to Medicaid eligibility. Eligibility workers examine financial records during the application period to determine whether unapproved transfers have been made. Applicants are declared ineligible for long term care Medicaid coverage if there is
evidence of improper transfers. A penalty period begins on the date the transfer was made. The transferred resources would equal a number of weeks or months of nursing home care that could have been purchased with those funds. Nursing home residents who qualify as medically needy are expected to apply their available income toward the cost of their own nursing home care and may keep only a small monthly personal allowance of $35 to cover items such as clothing, toiletries, books etc (Robin Jones, personal communication, October 14, 2010). Medicaid eligibility rules are more generous for nursing home residents who have a spouse who remains in the community. The impoverished spouse protection requires states to disregard the income of the community spouse and to supplement it if necessary. A community spouse is allowed to keep half of the couple’s joint assets. Federal law requires states like California to allow a community spouse to keep as much as $109,560 in 2009 and a minimum monthly maintenance need allowance of $2,739 per month (State of California DHCS Letter No: 08-49).

Demographics of Aging Persons

Many consider older persons as those at least sixty years of age and older. Harrington et. al. (2002) defines the categories as follows: the young-old (fifty-five to sixty-four), the old (sixty-five to seventy-four), the older old (seventy-five to eighty-four), and the much older person (eighty-five and older). The estimate for people aged 65 and older in the United States is 12.4% of the U.S. population, approximately 33.5 million people (U.S. Bureau of the Census, 2000). The numbers of these elders is increasing at rapid pace with the increase of life expectancy and baby boomers reaching
old age. Baby boomers will reach old age between the years 2020 and 2030, and one in five will be over the age of 65. Increased life expectancy means that the older-old have increased tremendously. There is an increase in the number of older person, especially in the older-old age range (those in the seventy-five to eighty-four age range) (American Association of Retired Persons [AARP] as cited in Sheridan & Kisor, 2000. The estimated population of San Joaquin County from the U.S. Census Bureau 2005-2007 American Community Survey is 664,423. 65,347 were 65 years of age and over with a medium age of 74.9 years. As of 2005 San Joaquin County was ranked 112 out of 638 counties by population aged 65 and over by the US Census with counties with 10,000 or more people aged 65 and over. Health and quality of life issues will continue to be a major concern as Americans age (Sheridan & Kisor, 2000). With greater health concerns, more elders will be in need of nursing home care.

Summary

The literature review provided an overview of various factors related to the impact in decision-making and advocacy within a skilled nursing facility. Business, nursing, and social work models are vastly different in their foundational aspects as well as their primary foci. These aspects are interrelated in patient advocacy yet are in such conflict that effective advocacy is seriously impaired. The strengths and aspects of each discipline must be integrated to create an innovative and effective advocacy approach that will serve the anticipated surge of residents who will be in need of such advocacy in the coming years.
Statistics project a major rise in the aged population compared to total population in the coming decades. Nursing homes are an important module of long-term care as the growth of our elderly population augments. Skilled nursing facilities developed from the medical model, emphasize a minimum quality of care with little thought and effort given to quality of life. More than twenty years have passed since the 1987 Nursing Home Reform Act that required across-the-board changes in federal standards to improve the quality of care in nursing homes but the problem continues as facilities phase in and out of compliance. Implementation has been slow and continued quality of care is far from complete. Additionally, resident, staff and family expectations have shifted over the last twenty years creating further obstacles for facilities. Nursing home residents still experience poor care and neglect far too frequently. Consumer advocates like family, friends or legal representatives play an important role in advocating for good quality care. Their involvement can improve life for nursing home resident’s one person at a time. Residents need support and encouragement to exercise their rights.
Chapter 3

METHODS

Introduction

This chapter will describe the methodology, research design used for this study, including the population being examined and methods used for obtaining the sampling procedures. This chapter concludes with a discussion of human subject protection.

Research Questions

What strengths and aspects of each discipline; administration, nursing and social work, can be integrated to produce an effective multi-disciplinary approach to resident advocacy?

Research Design

For this study, the researchers will use an exploratory qualitative design. A qualitative type design allows the researchers to uncover new insights, generate ideas for new research and discover new information about the phenomena (Rubin & Babbie, 2001). There are many advantages and disadvantages to using a qualitative research approach. One advantage is that the researcher comes in direct contact with the participant, and is able to record their reactions and interactions within their own environment. The researcher is able to control the interview and ask follow up questions, as necessary (Creswell, 2003). In contrast, the disadvantages to consider using the qualitative research method are that fewer participants are sampled and it is difficult to replicate a qualitative study. The face-to-face process of collecting data may result in eliciting a biased response (Creswell, 2003).
The study included a cross-sectional questionnaire completed by facility administrators, D.O.N’s, and Ombudsman volunteers. A convenience sample was used due to all facilities within the boundaries of San Joaquin County were included with the exception of specialized care facilities. Cross sectional studies can make studying a population easier (Rubbin & Babbie, 1997). Ombudsman volunteers were accessed through a regularly scheduled meeting at the Department of Aging in San Joaquin County therefore only those who attended were provided the opportunity to participate. A collection of qualitative data, from each discipline previously researched in the literature review, provided information in which to create an advocacy handbook useful by numerous aspects of resident care. The researchers were unable to find a reasonable source of material in the discipline of social work, nursing or administration, which led to the current study. Researchers conducted an exclusive survey to determine factors that lead to complaints by facility staff and family members. The researchers anticipated that the data would uncover information that was then utilized to create an effective and non-adversarial method in which loved ones could effectively advocate for residents.

*Study Population*

The researchers will conduct a survey in each of the twenty-six identified skilled nursing homes located in San Joaquin County. Inclusion was based solely on geographic location and stand-alone status. Five skilled nursing home facilities identified as sub acute were excluded due to their association within a hospital setting or specialized end of life care. The survey was administered to each of the facilities administrators as well as the head of the nursing department, typically referred to as the DON. The Administrator
and DON were chosen to be surveyed based on their power and ability to change culture in their respective facilities.

San Joaquin County currently has twenty-eight voluntary Ombudsman assigned to investigate and mediate any concerns related to resident care in a skilled nursing facility. The researchers made contact with the volunteers through an invitation to present at their monthly meeting in January 2010. The researchers invited all members of this group to participate. The only requirement for inclusion within this group was status as a San Joaquin County Ombudsman volunteer. No member belonging to this group was excluded. The researchers personally invited San Joaquin County Ombudsman volunteers to participate in the study.

Data Gathering Procedures

Data for this study are based on personal interviews with administrators, director of nursing and Ombudsmen. There are twenty-six skilled nursing facilities with in San Joaquin County that were identified for data collection. There will be twenty-six possible respondents. During the interview, each respondent will reply to a questionnaire filled out by the interviewer.

Survey Instrument

One of the researchers will administer the questionnaire during the actual interview by reading each question to the respondents. After reading each question, the researcher will record the answers. The questions center on the roles and functions of an administrator, director of nursing and social services designee.
**Sampling Procedure**

The sample population for this study will include the twenty-six identified skilled nursing facilities. The researchers will telephone call each of the identified skilled nursing facilities and set up appointments for personal interviews. The interview will take approximately thirty minutes. The researcher will follow the question wording and sequence as written, recording each response exactly as they are given. The skilled nursing facilities participation will be on a voluntary basis. They may reply to all or part of the survey. However, if skilled nursing facility respondents are unwilling to participate, a promise of confidentiality may encourage them to participate.

**Protection of Human Subjects**

In accordance with the project requirements at California State University, Sacramento, a human subjects application was submitted to the Committee of Human Subjects from the Division of Social Work. The committee approved the proposed study and determined the project as “minimal risk” to the participants, as the human subjects answered questions related their professional work and training. The application included the consent form used for the study. The researches received the approval prior to initiating the collection of data.

Each participant of the study was given a consent form (See Appendix B). This form explained the purpose of the survey, the procedures, risks, benefits, compensation, and their right to not complete the survey. The consent form also indicated that confidentiality would be strictly upheld in order to protect their privacy. The participants consented by signing or initialing the consent form.
Confidentiality was upheld by not collecting names or identifying information. The completed consent forms were stored separately from the completed surveys in a locked cabinet in a secure location at the researcher’s home. The researchers and the researcher’s project advisor were the only people who had access to the completed surveys during the completion of the project. The data will be destroyed approximately one month after the project is filed with Graduate Studies at California State University, Sacramento.
Chapter 4

SKILLED NURSING FACILITIES HANDBOOK- A RESOURCE GUIDE

Introduction

The purpose of this handbook is to guide the advocacy of relatives in a positive direction. The handbook contains regulations related to the care of resident’s in a skilled nursing facility, financial information regarding Medi-Cal and Medicare, legal agreements, resources for community services, and practical measures that can be applied for proactive advocacy. The handbook is not all-inclusive and should not be considered as such. As a resident advocate the hope is that, you will educate yourself about the applicable laws and will remain an active part of your loved ones life. By understanding, the common concerns and issues seen in skilled nursing facilities you will be able to plan your loved ones transition into long-term care placement. This planning will assist in avoiding the pitfalls related to poor communication, differences in ideology and negative feedback loops that create adversarial approaches to advocacy.

The handbook is divided into sections by topic. Each topic discusses aspects of client advocacy and care. The main topics of the handbook include evaluation of nursing homes, admission agreements, resident’s rights, laws and regulations. Each section contains a subsection related to these main areas and includes answers to common questions. The handbook should be utilized by viewing the section associated to the issue at hand. If questions cannot be answered by the related section then a more comprehensive search should be done in the official legal or regulatory codes. Each portion of the subsection that is directly related to an associated regulation or law
includes the regulation number that can be accessed per the actual legal and regulatory codes. The laws and regulations are listed by the acronyms within the handbook. The official names of each legal and regulatory code source began on page 63 and will guide a search of where to find the associated law or regulation.
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**What is a Nursing Home in California?**

All nursing homes in California must be licensed by the California Department of Public Health (DPH) and meet California nursing home standards.

In addition to being licensed, nursing homes that choose to participate in the Medicare and Medi-Cal programs must be certified by the federal government in order to qualify for payments from these programs. Federally certified facilities must meet federal standards as well as the California requirements.

Most California nursing homes are certified to participate in both Medicare and Medi-Cal.

All nursing homes are not alike. There are several types of licensing and certification categories for nursing homes, which are described below:

Most nursing homes in California are licensed as **Skilled Nursing Facilities (SNFs)**, which California broadly defines as a health facility that provides skilled nursing and supportive care to persons who need this type of care on an extended basis.

Medicare also uses the term “skilled nursing facility” for nursing homes that are certified to receive its payments. Medi-Cal uses a similar term, “nursing facility (NF),” for nursing homes that are certified to receive Medi-Cal payments. Most, but not all, licensed skilled nursing facilities in California are certified to participate in Medicare and Medi-Cal.

**A Distinct Part/Skilled Nursing Facility (DP/SNF)** is a hospital-based facility, usually operated in a designated unit within a hospital. These facilities are paid higher Medi-Cal rates than freestanding nursing homes.
Medi-Cal contracts with certain skilled nursing facilities to provide *subacute care* to adults and children who need specialized care. Subacute care is a Medi-Cal program (not a licensing or certification category) that pays higher rates for Medi-Cal beneficiaries who have exceptional needs, such as ventilator care.

**How to Choose a Nursing Home**

**What to Look for...How to Choose a Facility**

Choosing a nursing home for a family member is one of the most difficult decisions in life. It is a stressful, time-consuming task that is often made worse by the fact that a loved one has suffered a medical crisis. You may face great pressure to locate a nursing home and arrange care in a very short period of time.

Fortunately, there are time-tested methods for identifying and evaluating nursing homes. Some important factors to consider include the location of the home, its participation in the Medicare and Medi-Cal programs, its compliance with public standards, and whether its services meet your needs and desires.

**Consult CANHR’s Nursing Home Guide or Medicare Nursing Home Compare**

CANHR’s online guide (www.nursinghomeguide.org) has in-depth information on all 1300+ nursing homes in California, including interactive searches, comparisons and details on violations, staffing and services. Get started by using Nursing Home Guide to learn about nursing homes in your community and find out about their histories of complaints, deficiencies and citations. Additionally, lists of nursing homes by county are available at CANHR’s main website (www.canhr.org). Medicare Nursing Home Compare online guide
(http://www.medicare.gov/NHCompare/Include/DataSection/Questions/ProximitySearch.asp) can search under name of a facility, zip code, city, state, and county.

**Medicare and Medi-Cal Considerations**

If you want Medicare or Medi-Cal to help pay for the nursing home care, you must select a facility that is certified by these programs. Due to the extremely high cost of nursing home care – which averages above $200 per day or $6,000 per month – few people can afford to pay privately for very long. Most California nursing homes participate in both Medicare and Medi-Cal.

Medicare’s short-term skilled nursing facility benefit is very limited, but is often helpful to gain admission to a nursing home, especially when skilled nursing care or therapy are needed after hospitalization due to a stroke, surgery, injury or other medical conditions. Medicare covers up to 100 days of skilled nursing care following a hospital stay of at least three days.

Medi-Cal helps pay nursing home care for two-of-every-three residents in California. Due to the high cost of nursing home care, most people in nursing home’s will meet Medi-Cal’s financial eligibility requirements sometime during their stay. CANHR’s website provides extensive information on Medi-Cal eligibility for nursing home care (www.canhr.org).

Even if you don’t need or qualify for Medi-Cal now, it is best to select a Medi-Cal certified facility. Uncertified facilities can evict you when your money and insurance runs out. Your choice of other facilities at that point may be very limited. Medi-Cal certified facilities cannot evict residents who qualify for Medi-Cal during their stay.
Nursing Home Evaluation Checklist

The following checklist will give you, as an observer, a general idea of the quality of care provided in a nursing home. Depending on a resident’s needs, preferences and payment source, questions will vary.

Ask to see the entire facility, not just the nicely decorated lobby and one wing or floor. Remember that appearances can be deceptive. Though environment is important, try to get a feel for the care provided and how the residents are treated by staff.

Staff

• Are there adequate staff? What is the staff to resident ratio? Are call bells and resident requests responded to in a timely manner (5 minutes or so)?

• Are the staff courteous to residents? Do they treat residents with dignity and respect? Or is the staff attitude condescending? Are childish or otherwise inappropriate nicknames used when speaking with residents? Do staff talk about residents as if they were not present or as if they were children?

• Does the administrator/manager and director of nurses appear to know the residents?

• Is the administrator friendly and receptive to questions?

• Is privacy respected (e.g., knocking on doors before entering rooms, keeping privacy curtains drawn while care is being given)?

• Do staff wear name-tags?

• Are there therapists on staff or does the facility contract out for therapy?

• Is there a licensed social worker on staff? Full-time?
• Does the facility have permanent full-time nurses and certified nurse assistants (CNA’s) or are registry nurses and aides used?
• Are the staff visible and actively assisting residents?
• In addition to English, what languages does the staff speak?
• What is the facility’s communication strategy when a resident’s first language is not English?
• Does the facility conduct background checks before hiring staff?

**Resident Appearance**

• Are residents up and dressed for breakfast? Does the staff get them up hours before breakfast (too early) or just before lunch (too late)?
• Are the residents well-groomed (shaved, clothes clean, hair combed, nails trimmed and clean)?
• Do residents appear alert, content and occupied? Or are they lethargic, listless or stuporous?
• Are residents comfortably positioned in comfortable chairs? Are they restrained in their chairs or beds? Are they in chairs that have a tray or “lap buddy?”

**Resident Rooms**

• In which area of the facility would the resident’s room be located?
• How many residents share a room? Generally, rooms should have no more than four beds, at least three feet apart, with privacy curtains around each bed.
• Does each bedroom have a window?
• Is there a bedside stand, reading light, chest of drawers, and at least one comfortable chair for each resident? Is there adequate storage space and is it separate from other roommates?
• Are the beds easy to reach? Is there room to maneuver a wheelchair or Gerichair easily?
• Are call buttons accessible to residents?
• Is there fresh drinking water at the bedside?
• Are residents allowed and encouraged to bring any of their own belongings or furniture?
• Have residents personalized their rooms?

**Facility Environment**

• Is there an obvious odor in the facility? Strong urine and body odors may indicate poor nursing care or poor housekeeping. Heavy “air freshener”, deodorants, and other temporary chemical cover-ups may be substitutes for conscientious care and maintenance.

• Is the facility maintained at a comfortable temperature? Do the rooms have heating, air conditioning, and individual thermostats?

• Is the facility clean, well-lit and free of hazards? Do you see soiled linen or is it properly disposed of? Is there adequate linen?

• Is furniture sturdy and comfortable?

• Are floors clean and nonslippery?

**Hallways, Stairs and Lounges**

• Are halls free of obstacles and debris?

• Are stairways and exits clearly marked?
• Are there handrails in all corridors?

• Are fire extinguishers visible? Is there a disaster plan posted and does the facility have drills?

• How many lounge areas are available for residents and visitors? Are they clean and comfortably furnished? Is there sufficient room for visiting?

**Bath and Shower Rooms**

• Are bathrooms conveniently located?

• How many residents share a bathroom?

• Do bathrooms have handgrips or rails near all toilet and bathing areas?

• Is there a call button near the toilet?

• Do residents have a choice between a shower or bath, how frequent and during which shift?

**Kitchen and Dining Areas**

• Is the kitchen clean and well-organized?

• Is the food handled and stored in a safe and sanitary manner?

• Is the dining area pleasant, clean and comfortable?

• How many residents eat in the dining area? Is it large enough to accommodate most of the residents? Are there shifts for meals?

• Do chairs fit under the table so that residents are comfortably close to their food?

**Menus and Food**

Try to visit the facility during a meal. Observe the way the food is served, how residents
are assisted with eating and what their reaction is to the food. You can probably buy a meal to sample the food.

• A menu for the current and following week should be posted. If a menu is not posted, ask to see one. Is the food listed on the menu actually being served?

• How often are meals repeated? Are alternatives available, as required by law?

• Does the food appear and smell appetizing? Is it nutritious? Are fresh foods used, or is it mostly canned or frozen? Do residents enjoy the food?

• Are dishes and silverware used, or are disposable plates and utensils used?

• Are those residents who need assistance with eating and who are being fed by nurse’s aides finishing their meals and eating at their own pace? Are assistive devices available to those who may be able to feed themselves with a little help?

• Are meals served at appropriate temperatures?

• What provisions are made for patients who are unable to eat in the dining room?

• Who plans the meals? Is a professional dietician on staff? How are special dietary needs met?

**Activities**

• Are activity calendars posted? If not, ask for a description of the activity program. Meet the Activity Director if possible.

• Do the activities cover a broad range of interests?

• Are activities tailored to individual preferences?

• Does the facility have outside areas for resident use? Does staff assist the residents in using these areas?
• What activities are available to residents confined to their rooms?

• Do volunteers visit the facility?

• What arrangements are made for residents to participate in religious services of their choice?

• What is done for holidays and birthdays?

• Is there a resident council? When does it meet and what is its function?

Miscellaneous

• Is there a Family Council? When does it meet and who are the officers?

• How often do residents’ physicians visit the facility? It should be at least once every 30 days.

• How long has the facility been operating under the present management? Are there any plans to change in the near future?

• What hospital is used in emergencies?

• What is the billing procedure?

• Who should be contacted when there is a problem?

• How does the facility notify the resident and family members of the time and place of the quarterly care planning meetings?

• Is the Ombudsman Program’s phone number posted?

• Are the results from the last inspection by the Department of Public Health posted?

• Ask to review a copy of the admission agreement. Does the facility demand a “responsible party” signature? What is their “informed consent” policy?

• What is included in the basic costs and what is extra?
• If you are looking at an Alzheimer’s Unit within a facility, what makes it different from the rest of the facility (especially if it costs more)?

• How is transportation provided for trips to hospitals, medical offices, or community functions? Is there a charge?

• How is personal laundry handled?

• Is there a system to protect wanderers? Is it operational? Ask for a demonstration.

**Nursing Home Admission Agreements**

Buyers beware! An admission agreement is a legal contract that states the responsibilities of the nursing home and the resident. Before signing an agreement, read and study it carefully. Although California and federal laws regulate nursing home admission agreements, the contracts are written by the nursing home and seek to protect its interests. Studies of admission agreements have found that many contain misleading and illegal provisions. Never sign an agreement you do not understand. You have the right to take a copy of the agreement home to study, to ask questions about its terms and, if necessary, to seek changes.

**Before Signing an Admission Agreement, Take These Steps:**

• Read the agreement and all documents to which it refers, such as a listing of charges, information on resident rights, and consent agreements.

• Develop a list of all your questions about what is contained in the agreement.

• Make sure that all your questions are answered to your satisfaction before signing.

• Use the agreement as an opportunity to clarify expectations and to negotiate care needs and costs.
• Consider having the document reviewed by an attorney or consumer advocate.

**California Standard Admission Agreement on Hold**

In 1997, California’s legislature passed SB 1061, a law requiring nursing homes to use a Standard Admission Agreement to be developed by the California Department of Public Health (DPH) and to be implemented by January 2000. Years after it was due, DPH established a Standard Admission Agreement and began requiring nursing homes to use it on January 2, 2006. However, use of the agreement has been suspended due to a court order obtained by nursing home operators who challenged it. DPH has announced that it is revising the Standard Admission Agreement to comply with the court order. Until DPH reissues the Standard Admission Agreement, some nursing homes may continue using the initial version. Most, however, are likely to use their own admission agreements, which are subject to the laws and consumer protections described below.

**Nursing Home Admission Agreements**

**Basic Requirements**

Each nursing home must make complete copies of its admission agreement immediately available to the public at cost, upon request. An admission agreement must be written in clear language, using words with common and everyday meanings. It must be printed in black type (at least 10-point type size) on just one side of plain white paper. Every admission agreement must clearly state whether the facility participates in the Medi-Cal program. If a nursing home has filed a notice of intent to withdraw from the Medi-Cal program, the agreement must state that it is no longer accepting Medi-Cal from newly admitted residents.
Notification of Rights

At or before admission, the nursing home must inform you about resident rights both orally and in writing in a language that you understand. The written description of rights must be comprehensive and be presented in at least 12-point type. The admission agreement must contain a separate written acknowledgement that you have been informed of the Patient’s Bill of Rights.

Read the description of resident rights carefully and compare it with the information in the admission agreement. Some admission agreements have terms that contradict your rights. Ask about any discrepancies you identify.

Requirements to Pay Privately

It is illegal for a Medicare or Medi-Cal certified nursing home to require a resident to pay privately for any set period of time. Applicants cannot be required to give assurances that they are not eligible for Medi-Cal or Medicare nursing home benefits or that they will not seek those benefits in the future. When residents qualify for Medi-Cal or Medicare nursing home coverage, nursing homes certified by these programs must accept their payments.

Some nursing homes require applicants to disclose financial information that is used to project how long they can pay privately before qualifying for Medi-Cal. Applicants with more money are usually given preference. Although this practice is of questionable legality, federal and California authorities allow it.
Responsibility for Payment

The resident is the only person whose funds must be used to pay a nursing home. However, many nursing homes try to get other persons to accept personal financial responsibility by signing the admission agreement as a responsible party. This practice is illegal.

To avoid this problem:

1. Do not sign as a “responsible party,” “guarantor,” “financial agent” or any other term that the admission agreement states is a person who personally guarantees payment of nursing home fees.

2. If you manage a Medi-Cal beneficiary’s finances, cross out improper terms and replace them with “agent” (not “financial agent”).

3. If you are the resident’s legal representative, such as a conservator, cross out improper terms and replace them with your legal role.

Agents and legal representatives are responsible to use the resident’s funds, not their own money, to pay lawful charges.

If a nursing home attempts to collect money from you because you signed the admission agreement as a responsible party, seek advice from a qualified attorney.

Deposits

A nursing home cannot require or accept a deposit if Medi-Cal or Medicare is helping to pay for a person’s nursing home stay. Nursing homes may require a deposit from private-paying residents. Deposits paid by private-paying residents must be returned when Medi-Cal or Medicare starts paying for their nursing home care.
Notice About Medi-Cal Eligibility

Prior to admission, Medi-Cal certified nursing homes must notify you about Medi-Cal eligibility standards, using a State mandated notice. The legislature required this notice after learning that some nursing homes misinformed applicants and residents about Medi-Cal eligibility. The notice contains important information, including:

- You do not have to use all your resources to qualify;
- Your home is an exempt resource. Its value does not affect your eligibility, and you have the right to transfer the home.
- Medi-Cal has special rules for married couples that protect resources and income for the spouse who is not in the nursing home. California law allows the community spouse to retain a certain amount of otherwise countable resources available to the couple at the time of application. This is called Community Spouse Resource Allowance (CSRA) and it increases every year according to the Consumer Price Index. The 2009 CSRA is $109,560. [http://www.canhr.org/factsheets/medi-cal_fs/html/fs_medcal_overview.htm](http://www.canhr.org/factsheets/medi-cal_fs/html/fs_medcal_overview.htm)

Notification of Charges

An admission agreement must describe services available in the facility and any related charges.

This includes any charges for services not covered by the facility’s basic rate or not covered by the Medicare or Medi-Cal programs. Medicare and Medi-Cal certified nursing homes must state that optional and covered services may be different for residents in those programs than for privatepaying residents. Medi-Cal certified facilities must give Medi-Cal beneficiaries a list of Medi-Cal optional and covered services.
Rate Changes

If a nursing home plans to increase the daily room rate or fees for optional services, it must give residents 30 days written notice of the changes.

Discharge Notification & Refunds

A resident can leave a nursing home without giving advance notice. An admission agreement cannot require advance notice of voluntary discharge.

You cannot be charged for any days of care after discharge unless you voluntarily leave the facility within 3 days of admission and Medicare and Medi-Cal are not paying for your nursing home care. In this situation, you may be charged for a maximum of three days at the basic daily rate. You are otherwise entitled to a refund of any advance payments made to the nursing home.

If a resident is discharged or dies, any advance payments must be returned to the heir or personal representative of the resident within two weeks after discharge or death.

Arbitration Agreements

To prevent residents from being able to sue for abuse or neglect, many nursing homes are asking new and current residents to sign admission agreements that include binding arbitration provisions. It is not wise to sign such an agreement.

By signing a binding arbitration agreement, you give up your constitutional right to go to court if a dispute arises in the facility, even if it involves abuse and neglect. There is no right to appeal a decision made through binding arbitration. An arbitration agreement should be signed voluntarily and without coercion only after you have had an opportunity to seek and consider legal advice about how to handle a dispute.
Nursing homes cannot require you to sign an arbitration agreement. Any arbitration clause must be on a form separate from the admission agreement and require separate signatures for approval.

Residents and their legal representatives can rescind an arbitration agreement by giving written notice to the facility within 30 days of their signature.

**Consent to Treatment**

A nursing home cannot legally require you to sign an agreement consenting to any treatments it or its physicians may recommend. Admission agreements may only require consent for routine nursing care or emergency care. Even if you sign a consent agreement for routine nursing care at admission, you always have the right to refuse any type of care at any time for any reason.

**Advance Directives**

Advance directive is the general term used to describe instructions regarding preferences for future medical treatment. At admission, the nursing home must give you written information about advance directives explaining: (1) your right to direct your own health care decisions; (2) your right to accept or refuse medical treatment; (3) your right under California law to prepare an advance health care directive; and (4) the facility’s policies that govern the use of advance directives.

Although it is a good idea to have an advance health care directive, facilities cannot require you to have or to make one. If you already have an advance health care directive, give a copy of it to the nursing home so it will know about your instructions.
**Epple Act**

When a resident is no longer capable of making their own health care decisions and there is no surrogate decision maker and/or advance directives, the facility interdisciplinary team, alone with the attending physician, can make health care decisions for the resident in the resident’s best interest. See SECTION 1418.8 of the California Health and Safety Code.

**Confidentiality**

The admission agreement must inform you of the right to confidential treatment of health information and provide you a voluntary means to authorize disclosure of information to persons of your choice.

**Personal Possessions**

At admission, the nursing home must establish a personal property inventory and give the resident or personal representative a copy of it. Keep the inventory sheet current and maintain a copy. However, it is best to limit the number of personal belongings that are kept at the facility.

**Theft and Loss**

The loss of personal property is a prevalent problem for the residents and relatives of love ones in care facilities. Taking precautions to prevent loss or theft of personal property is a shared obligation of the resident, the resident’s family, the administration of the facility, the facility staff and the Ombudsman program. Any time new items are brought into or taken out of the facility; they should be added to or deleted from the inventory list.

NOTE: the facility is only responsible for those items on the inventory list and when
reasonable efforts have not been made to safeguard resident property. Report any missing items to the facility administrator immediately.

**Waiver of Liability Statements**

Some admission agreements claim that the nursing home cannot be held responsible if a resident is injured or a resident’s property is lost, stolen or damaged. These types of waiver of liability statements are illegal and unenforceable.

**Notification of Grievance Procedures**

An admission agreement must notify you that the nursing home’s grievance policy is available. It must also inform you of the right to contact the California Department of Public Health or the longterm care ombudsman, or both, about grievances against the facility.

**How Can I Address Illegal Requirements?**

- Seek legal advice from a qualified attorney or consumer advocate.

- Notify the nursing home of your concerns and negotiate changes. If you succeed, draw a line through the words to be changed and add words per your agreement. Place your initials next to the changes and ask the facility representative to do the same. Ask for a copy of the signed admission agreement.

- File a complaint with the Department of Public Health:

**Sacramento District Office**

3901 Lennane Drive, Suite 210

Sacramento, CA 95834
Signing the Agreement

Prior to or at admission, nursing homes must ask the prospective resident to sign the admission agreement after informing him or her of its content. Except as noted below, no one else can be required to sign the agreement unless the prospective resident is legally incompetent or is medically incapacitated. If so, the prospective resident’s legal representative can sign the agreement on his or her behalf.

The exception involves Medi-Cal beneficiaries. A person who manages or controls the funds and assets of a Medi-Cal beneficiary, called an agent, can be asked to sign or co-sign the admission agreement. However, the agent does not assume any personal financial responsibility by doing so, except with regard to paying the share of cost.

**BE SURE TO KEEP A SIGNED COPY OF THE ADMISSION AGREEMENT!**

*The most pertinent laws and regulations regarding nursing home admission agreements are found in:*

**California Health & Safety Code:** Sections 1288(a), 1289.3–1289.5, 1418.7, 1439.8, 1599.60–1599.84, 1599.85–1599.89;
California Welfare & Institutions Code: Sections 14006.3, 14006.4, 14019.3, 14022.3, 14110.8, 14110.9, 14124.10, 14134.6;

California Health Care Decisions Act, AB 891, 1999;

California Code of Civil Procedure: Section 1295;

Title 22 of the California Code of Regulations: Sections 72520(b), 72527(a), 72528(g), 72529, 72531, 72543, 72545;

United States Code: Sections 42 USC 1396r(c)(1)(B), 42 USC 1396r(c)(2)(E) & (F); 42 USC 1396r(c)(4) & (5), 42 USC 1396r(e)(6); 42 USC 1395i–3(c)(5); 42 USC 1395cc(f)

Code of Federal Regulations: Sections 42 CFR 483.10, 483.12(c) & (d), 42 CFR 431.20, 42 CFR 489.102.

Admission Agreement Checklist

Items to be included in the contract:
• Services included in the daily rate
• Services that have an extra charge
• Source of payment, such as Medi-Cal or Medicare
• Cost to the resident
• Terms of the security deposit, if any
• Additional provisions agreed to by both parties

At the signing, make sure you receive:
• A receipt for advance payment and/or security deposit, if any
• A receipt for money deposited in the resident’s trust fund, if any
• The written facility policy concerning protection of resident trust funds and the right of
Residents to manage their own funds

- The statement of residents’ rights
- The notice explaining Medi-Cal eligibility
- A written explanation of how to apply for and use Medicare and Medi-Cal benefits
- A list of available facility services and their costs
- If the resident is a Medi-Cal beneficiary, a list of Medi-Cal covered and optional services
- The facility’s written policy on advance directives
- The facility’s written policy on holding a bed when hospital care is needed
- The facility rules governing resident conduct
- A copy of the signed admission agreement and all attached forms—make sure that your copy includes all changes and that they have been initialed by you and the facility representative
- The facility’s written theft and loss policies and procedures

**Make sure the nursing home has attached to the contract:**

- A signed inventory of the resident’s clothing and personal belongings
- A signed copy of any additional agreements you have made with the facility
- A copy of every other document you signed at admission

**Residents’ Rights**

Residents of nursing homes have rights under both federal and state law. Nursing homes are required to inform residents of these rights and protect and promote their rights. If a resident is incapable of exercising his or her rights, the person designated by law, such as
conservator or attorney-in-fact, or in most cases, the next of kin, or representative payee, may exercise these rights.

**Grievances**

The resident has the right to:

- Exercise rights, voice grievances, and recommend changes in policies and services to facility staff and/or outside representatives of the resident’s choice, free from restraint, interference, coercion, discrimination or reprisal. (42 C.F.R. §483.10(f)(1))

- Prompt efforts by the facility to resolve grievances the resident may have, including those having to do with other residents. (42 C.F.R. §483.10(f)(2))

**Admission Agreements**

The resident has rights about the content of admission agreement contracts, which are signed at the time the resident enters the nursing home:

- The contract may not require that the resident pay with private funds (i.e. with funds that are not Medicare or Medi-Cal) for a specified period of time. (Cal. Health & Safety Code §1599.69(a))

- The contract may not require, at the time of admission, the resident to give notice that he or she intends to convert to Medi-Cal status. (Health & Safety Code §1599.69(b))

- The contract may not require the resident to promise not to apply for Medicare or Medi-Cal benefits. (42 C.F.R. §483.12(d)(1)(i-ii))

- The contract may not require a third-party guarantee of payment as a condition of admission or expedited admission. (42 C.F.R. §483.12(d)(2); Cal. Welfare & Institutions Code §14110.8(b))
In addition, a resident has the right to have his or her security deposit returned:

- When the resident converts to Medi-Cal. (Cal. Health & Safety Code §1599.70(b); Cal. Welfare & Institutions Code 14110.8(d))

**Medical Condition and Treatment**

The resident has the right to:

- Be fully informed by a physician of his or her total health status and to be afforded the opportunity to participate on an immediate and ongoing basis in the total plan of care. (42 C.F.R. §483.10(b)(3))
- Be fully informed in advance about care and treatment and of any changes in care or treatment that may affect the resident. (42 C.F.R. §483.10(d)(2))
- Participate in planning care and treatment or changes in care or treatment unless adjudged incompetent or otherwise found to be incapacitated under State law. (42 C.F.R. §483.10(d)(3))
- Self-administer medications unless doing so would be dangerous. (42 C.F.R. §483.10(n))
- Choose a personal attending physician. (42 C.F.R. §483.10(d)(1))
- To consent to or refuse any treatment or procedure or participation in experimental research. (42 C.F.R. §483.10(b)(4))
- To receive all information that is material to his or her decision concerning whether to accept or refuse any proposed treatment or procedure. (42 C.F.R. §483.10(b)(8))

**Protection of Resident Funds**

The resident has the right to:
• Manage his or her financial affairs. The facility may not require residents to deposit their personal funds with the facility although a resident can if he or she so desires. (42 C.F.R. §483.10(c)(1))

• Have funds entrusted to the facility held separately from the funds of the facility and from those of other residents, and have an accurate accounting of those funds. Funds over $50 must be held in an interest-bearing account. (42 C.F.R. §483.10(c)(3))

• Be informed when the amount in the resident’s account, if managed by the facility, reaches $200 less than the $2000 Medi-Cal resource limit and, if increased, may cause the resident to be disqualified from Medi-Cal. (42 C.F.R. §483.10(c)(5))

**Transfer and Discharge**

The resident has the right to be transferred or discharged only if:

• He or she has recovered to the point of not needing nursing home care. (42 C.F.R. §483.12(a) (2)(ii))

• It is necessary for the resident’s welfare and her/his needs cannot be met in the facility. (42 C.F.R. §483.12(a)(2)(i))

• The health or safety of others is endangered. (42 C.F.R. §483.12(a)(2)(iii) and (iv))

• He or she has failed to pay for care. (42 C.F.R. §483.12(a)(2)(v))

• The facility ceases to operate. (42 C.F.R. §483.12(a)(2)(vi))

Other rights regarding transfer or discharge from a nursing home:

• A nursing home must give both the resident and a family member or legal representative advance notice of the transfer or discharge as soon as practicable or
reasonable, or in some cases, at least 30 days in advance. (42 C.F.R. §483.10(b)(11)(D), §483.12(a)(4), (5); Title 22, Cal. Code of Regulations §72527(a)(5))

- A nursing home that participates in the Medi-Cal program may not transfer or seek to evict a resident when he or she changes from private pay or Medicare to Medi-Cal, or while the Medi-Cal application is pending. (42 C.F.R. §483.12(c)(1); Cal. Welfare & Institutions Code §14124.7(a))

- The nursing home must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. (42 C.F.R. §483.12(a)(7); Cal. Health & Safety Code §1599.78)

- The nursing home must produce a discharge summary that includes a post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living arrangement. (42 C.F.R. §483.20(l)(3))

- The resident has a right to a 7-day bedhold and immediate readmission when transferred to a general acute care hospital, if he or she continues to pay for the nursing home bed. (42 C.F.R. §483.12(b); Cal. Health & Safety Code § 1599.79; Title 22, Cal. Code of Regulations, §72520(a))

- After a hospitalization, the resident has the right to be readmitted to the nursing home’s first available bed, if the nursing home fails to give written notice of the resident’s right to a 7-day bedhold. (Cal. Health & Safety Code §1599.79; Title 22, Cal. Code of Regulations, §72520(c))
• After a hospitalization, a resident who is a Medi-Cal recipient has the right to the
nursing home’s first available bed even if he or she is absent from the nursing home for
more than 7 days. (42 C.F.R. 483.12(b)(3))

**Chemical & Physical Restraints & Abuse**

The resident has the right to:

• Be free from verbal, sexual, physical, and mental abuse, corporal punishment, and
involuntary seclusion. (42 C.F.R. §483.13(b))

• Be free from any physical or chemical restraints—either psychotherapeutic or
antipsychotic drugs—imposed for purposes of patient discipline or staff convenience
which are not required to treat the resident’s medical symptoms, except in an emergency
which threatens to bring immediate injury to the resident or others. (42 C.F.R.
§483.13(a))

• Be given the necessary information to be able to refuse or accept the use of
psychotherapeutic drugs, physical restraints, or the prolonged use of a device that may
lead to the inability to regain use of normal bodily functions, which will allow the
resident to give informed consent about the use of these methods. (Title 22, Cal. Code of
Regulations §72528(c))

Based on a comprehensive assessment of a resident, the facility must ensure that:

• Residents who have not used antipsychotic drugs are not given these drugs unless
antipsychotic drug therapy is necessary to treat a specific condition. (42 C.F.R.
§483.25(l)(2)(i))

• Residents who use antipsychotic drugs receive gradual dose reductions or behavioral
programming in an effort to discontinue these drugs, unless clinically contraindicated. (42 C.F.R. §483.25(l)(2)(ii))

• The facility must ensure that each resident’s drug regimen is free from unnecessary drugs. (42 C.F.R. §483.25(l)(1))

**Resident Records**

The resident has the right to:

• Personal privacy and confidentiality of his or her personal and clinical records. (42 C.F.R. §483.10(e))

• Review all records pertaining to the resident upon oral or written request within 24 hours, and to purchase photocopies of these records with two days advance notice. (42 C.F.R. §483.10(b)(2))

• Approve or refuse release of records to any individual or agency outside the facility except when transferred or required by law. (42 C.F.R. §483.10(e)(2) and (3))

**Dignity and Privacy**

The resident has the right to be treated with consideration, respect and full recognition of dignity and individuality (42 C.F.R. §483.15(a)). This includes the right to:

• privacy during treatment and personal care; (42 C.F.R. §483.10(e)(1))

• receive and make phone calls in private; (42 C.F.R. §483.10(k))

• send and receive mail unopened; (42 C.F.R. §483.10(i)(1))

• associate privately with persons of resident’s choice, inside or outside the facility. (42 C.F.R. §483.15(b)(2))
Free Choice and Participation

The resident has the right to:

• Refuse to perform services for the facility. (42 C.F.R. §483.10(h)(1))

• Choose activities and schedules consistent with his or her interests and care plan and to receive services with reasonable accommodation of individual needs and preferences. (42 C.F.R. §483.15(b)(1) and (e)(1))

• Participate in resident groups and in activities of social, religious and community groups. (42 C.F.R. §483.15(c)(1) and (d))

• Communicate with persons of one’s choice inside or outside of the facility. (42 C.F.R. §483.10)

• Retain and use personal clothing and possessions as space permits if it doesn’t infringe upon the rights or health and safety of other residents. (42 C.F.R. §483.10(l))

Access and Visitation

The resident has the right and the facility must provide—subject to the resident’s right to deny or withdraw consent at any time—immediate access to any resident by:

• Immediate family or other relatives of the resident. (42 C.F.R. §483.10(j)(1)(vii))

• Others who are visiting with the consent of the resident, subject to reasonable restrictions. (42 C.F.R. §483.10(j)(1)(viii))

• The facility must provide reasonable access to any resident by any entity or individual that provides health, social, legal or other services to the resident. (42 C.F.R. §483.10(j)(2))

• If a resident is married, he or she and their spouse must be assured privacy and to be
able to share a room if both are residents in the facility and both agree to do so. (42 C.F.R. §483.10(e)(1) and (m))

**Resident & Family Councils**

**Resident Councils**

- A resident has the right to organize and participate in resident groups in the facility. (42 C.F.R. §483.15(c)(1))

- The facility must provide a resident group with private space. (42 C.F.R. §483.15(c)(3))

- Staff or visitors may attend meetings at the group’s invitation. (42 C.F.R. §483.15(c)(4))

- The facility must provide a designated staff person responsible for providing assistance and responding to written requests from the resident council. (42 C.F.R. §483.15(c)(5))

- The nursing home must listen to the views, and act upon the grievances and recommendations of a resident council, concerning policies affecting resident care and life in the facility. (42 C.F.R. §483.15(c)(6))

**Family Councils**

- A resident’s family has the right to meet in the facility with families of other residents. A nursing home may not prohibit the formation of a family council. (42 C.F.R. §483.15(c)(2))

- A family council may be made up of family members, friends, or representatives of residents. (Cal. Health & Safety Code §1418.4(b))

- The family council must be allowed to meet in a common meeting room of the nursing home at least once a month, and to meet in private without nursing home staff present. (42 C.F.R. §483.15(c)(3); Cal. Health & Safety Code §1418.4(a), (c))
• Staff or visitors may attend family council meetings, at the group’s invitation. (42 C.F.R. §483.15(c)(4); Cal. Health & Safety Code §1418.4(e))

• The nursing home is required to consider the views, and act upon the grievances and recommendations of a family council, concerning proposed policy and operational decisions affecting resident care and life in the facility. (42 C.F.R. §483.15(c)(6); Cal. Health & Safety Code §1418.4(g))

• The nursing home is required to respond within 10 working days to written requests or concerns of the family council. (Cal. Health & Safety Code §1418.4(h))

These residents’ rights are found under both Federal and State law. The Federal rights are found in the Code of Federal Regulations (“C.F.R”), Title 42, which can be accessed online at [www.gpoaccess.gov/cfr/index.html](http://www.gpoaccess.gov/cfr/index.html).

The State rights are found in the Health & Safety and Welfare & Institutions Codes, which can be accessed online at [www.leginfo.ca.gov/calaw.html](http://www.leginfo.ca.gov/calaw.html) and in the California Code of Regulations, Title 22, which can be accessed online at [www.calregs.com](http://www.calregs.com).

The Licensing and Certification Program provides a packet of material designed to assist you in understanding Nursing Home Residents' Rights

[http://www.cdph.ca.gov/HealthInfo/Pages/NursingHomePatient.aspx](http://www.cdph.ca.gov/HealthInfo/Pages/NursingHomePatient.aspx).

**Recommendations and Common Themes**

• Your new role is to provide emotional support to your loved one, to help the staff know your loved one on a personal basis and to be the advocate. Four themes were common to almost all research participants of the study; visit often and at different times, communicate with staff, ask questions and let go of guilt
• Support the transition to the care facility (nursing home) by visiting frequently.

• Meet other residents, talk to staff and familiarize your self and your loved one to his/her new environment.

• Become involved in the care planning process right away. Assist the care facility in getting to know the resident and develop a transitional care plan eventually moving to a more comprehensive one.

• Monitor the needs, changes, and care of the resident during the transition.

• Be attentive to changes and communicate them to the appropriate staff at the care facility.

• Make your visits count by visiting at different times and shifts and on different days of the week. The unpredictability of your visits will give you a full picture of the patterns of care and the presentation of care staff at different shifts.

• Make a plan for weekly visits. Plan occasional outings, anticipate special occasions (birthdays, anniversaries, etc.), coordinate visits with family, friends and volunteers.

• Know the facility’s policy and procedures and who you should go to with concerns or problems. Offer positive feedback when concerns have been addressed or you see positive things in the facility.

• Participate in all care plan meetings or conferences. Skilled nursing facilities have quarterly reviews and this can provide an opportunity to evaluate the current plan or to make any necessary changes to improve the individualized plan of the resident.
• Use the care plan to monitor the overall care of your loved one. Keep notes, check records with the resident’s permission. The records are an accurate reflection of what is actually happening.

• Keep close contact with the resident’s doctor. Check on the medications that have been prescribed and monitor your loved one’s reactions.

• Make physical inspections in a non-intrusive way to inspect for redness or sores.

Making a Difference in Long Term Care

To be an effective advocate for your loved one it is eminent to be knowledgeable of the rights of the residents and your rights as an advocate of the resident.

• One of the most important rights is the right to express concerns, suggestions or to make complaints without fear of retaliation.

• Ask for a meeting with key (Director of Nursing, Social Worker, Activity Coordinator, OT/PT Therapist and Administrator) people to resolve the problems.

Do you have questions about nursing homes? The Ombudsman Program in San Joaquin County can help with:

• Resident’s Rights

• Legal matters including witnessing Advanced Health Care Directives

• Abuse, Neglect or Financial Exploitation

• Resident Care

• Medication, Food and Special Diets

• Medi-Cal Or Medicare

• Conservatorship
• Community Resources
• Activity Programs
• Cost or Itemized Charges
• State Inspection Reports
• Federal and State Regulations
• Care in the least Restrictive Environment
• Any other concerns affecting residents

The Ombudsman Services are FREE and Confidential

Who is an Ombudsman

• Is a trained state certified volunteer who works under the guidance of the California State Ombudsman.

• Is an advocate for the quality of life and care for residents in skilled nursing facilities and residential care facilities.

• Seeks to resolve complaints and concerns communicated by or on the behalf of residents of long-term care facilities.

• Works with facility administration and staff, state, county and local agencies, family members, concerned citizens objectively investigating and resolving issues that affect residents in long-term care facilities.

• Provides a presence in long-term care facilities through regular visits.

• Promotes public awareness.

The Ombudsman Program provides a number of critical services. Ombudsmen act as the eyes and ears for residents in long-term care facilities. Ombudsmen encourage access to
advocacy by informing residents of what kind of care to expect, by providing a mechanism to file a complaint, and by guiding residents through the process of advocating on their own behalf. The Ombudsman’s experience in long-term care facilities has shown that when residents and families understand the long-term care system, they are able to effectively act on their own behalf when problems occur. By educating residents, families and facility staff; the Ombudsman Program fosters an understanding and knowledge of the long-term care system.

If you are interested in learning more about the San Joaquin County Long-Term Care Ombudsman Program please call them at:

(209) 468-3785 or the Crisis Line at 1-800-231-4024.

Other Community Resources and Helpful Links

• The San Joaquin County Aging and Community Services provide numerous services and information for caregivers, service providers, and seniors. Whether you are a family member, friend, or paid professional, we hope you will find this information helpful as you assist the seniors and people with disabilities of our community

http://www.sjaging.org/

• The San Joaquin County Aging and Community Services Resource Directory 2009-10


• Skilled Nursing Facilities in San Joaquin County


• AARP http://www.aarp.org/
• AgeNet Eldercare Network www.agenet.com

• Aging America Resources www.agingusa.com

• American Association of Homes and Services for the Aging www.aahsa.org

• American Health Assistance Foundation www.ahaf.org

• American Lung Association www.lungusa.org

• American Society on Aging www.asaging.org

• California Commission on Aging www.ccoa.ca.gov

• California Department of Aging www.aging.ca.gov

• Flu Shot Locator - by: The American Lung Association www.flucliniclocator.org

• Housing & Community Development www.hcd.ca.gov

• Legislative Bills www.aging.ca.gov/legislation/budget_highlights.asp

• National Association of Area Agencies on Aging www.n4a.org

• U.S. Administration on Aging www.aoa.gov
Summary

The utilization of this handbook is to assist resident advocates in maintaining a positive working relationship with care providers within a skilled nursing facility. As an advocate educating yourself on the grading of facilities, laws and regulations, facility procedures and policies will be your best defense in avoiding miscommunication and misunderstanding that quickly become antagonistic at times. Clear communication and expectations between family and facility staff can provide the basis for positive interaction in years to come. Admission into long-term care can be a satisfying and agreeable situation that allows a loved one to be well cared for physically, psychologically, and emotionally. Admission can also allow relatives to step out of the care provider role and again enjoy their roles as daughters, sons, sisters or brothers. It is the hope of the researchers that family members will utilize the handbook created to effectively advocate in a way that encourages participation, communication, and mutual respect. Only when these aspects are included will resident advocacy truly be about the resident.
Chapter 5

CONCLUSIONS AND RECOMMENDATIONS

Introduction

This chapter summarizes the data collected through surveys completed by skilled nursing home administrators, D.O.N’s, and volunteer Ombudsman. Each group was surveyed in an attempt to gather data useful for creating an advocacy handbook that would encompass each discipline. This chapter will also provide recommendations for social work practice and future research.

Conclusions

In addition to the recommendations made by participants, they were also asked why they chose the profession that they are currently in. What may surprise some is that the majority of respondents chose their current paid or volunteer position based on their desire to serve others. As noted previously often skilled nursing facilities are demonized in the newspaper however, it appears that most truly care about the loved ones they care for. In contrast to the bottom line of the business model, seemingly coldness of the medical model and the sometimes-vague ideas of the social service model all come down to people who wish to serve others.

The surveys completed by skilled nursing home administrators, D.O.N.’s and volunteer ombudsman answered some foundational questions. Once completed the researchers reviewed each for common themes among the three disciplines in order to determine what factors are shared. The question reviewed asked for recommendations to family members that would assist them in advocating effectively for their loved ones.
Many themes were observed but four themes were common to almost all participants. The four recommendations are as follows; visit often and at different times, communicate with staff, ask questions, and let go of guilt.

Family members that visit often will be able to understand the processes and procedures utilized in skilled nursing facilities. This understanding will be beneficial to the family in curbing confusion about daily activities of their loved one. Family members must understand that their loved one is not going to receive the one on one care that they may wish due to the realities of nursing home structure. The 3.2 hours of nursing care that will be provided does meet legal definition but often feels neglectful by family standards. Visiting at different times of the day will also allow for family members to become acquainted with caregivers who need family expertise.

Communication is another aspect that is vital to effective advocacy. Family members that visit, call, attend care plan conferences, and share stories of their loved ones are providing some the basic factors of care, personalization. Family pictures are another way that family members can communicate. Pictures allow staff to ask residents questions and provide visual questions while providing care. Communicating previous functioning, behaviors, falls, and schedules will allow the facility to create a plan of care that is reasonable. Family members should be aware of their expectations and determine if the expectations are realistic and attainable. Often, family members seem to forget that their loved one has been unable to do many things prior to admission yet, they expect that those skills will miraculously return upon admission. Concerns should be communicated immediately and should not be allowed to fester, which often creates a larger problem.
Consistent communication can encourage more effective care by keeping staff updated on changes, needs and wishes of residents (Stern, 2001).

Asking questions of staff will also support effective advocacy. If family members do not understand something, they should ask politely. There are many reasons for why things may or may not be happening but family members will never know unless they ask. Questions regarding medication, oral care, rehabilitation, and diet restrictions are important things to know when visiting. Also noted in responses was the recommendation that family members fall the “chain of command”. C.N.A.’s are the primary caregivers and know residents better than anyone else in the facility. Questions should be asked of them and then up the chain of command as required. Care plan conferences are the perfect time to address many people at the same time. This time is scheduled specifically for you to address and discuss the needs of your loved one and should be utilized wisely.

One of the most important factors that were recommended to family members is to let go of the guilt. Resident’s wishes should be followed at all costs and the facility staff is there to ensure that they are. Unfortunately, family members are often riddled with guilt and other emotions which make this task extremely difficult. The discussion of resident’s wishes should occur prior to admission and should be clearly documented in an advanced healthcare directive. This directive will ensure that resident’s wishes are followed and that family members are not guilt ridden because of decisions that they had to make without the guideline in place. Guilt is also a large part of admission into a SNF. Most family members do wish to care for their loved ones at home but are often unable to
provide the level of care required. The feeling of guilt and failure is very common and can fuel issues at the SNF level simply due to the family members desire to be the caregiver and their inability to do so. Involvement in family councils, special events, and daily care routines can alleviate these feelings and provide a team approach to care giving that is much more beneficial to the resident. These councils are not particularly common in skilled nursing facilities and “of the more than 15,000 nursing facilities in the nation, less than half have family councils” (Persson, 2008, p.53). Creating a family council is an ideal way for family members to not only be involved in the facility but to assist others as well.

Recommendations

The research did support data from the literature review. Based on responses to the survey the holistic approach noted in the literature review is the most effective model. The model addresses all of the concerns noted by administrators, D.O.N.’s and ombudsman. The model creates a non-adversarial, team approach to care giving that supports family and professional involvement to address all of the resident’s needs. Each partner in the care giving is seen as an expert in their area, including the resident and their family members. The model would allow family members to actively participate in care hopefully alleviating their emotional biases. Administration and nursing would be able to utilize the knowledge of the family in order to facilitate a personalized plan of care. Lastly, by applying a team approach lines of communication would be developed that would encourage open and honest communication with all aspects of care.
Future research of cost effective means to apply this model as well as cultural changes in how we think about nursing home care are necessary. Several models exist in the United States and have been very effective. It is unknown as to why the skilled nursing industry has not embraced this model and continues to maintain a medical/business model setting. Research should also be completed with family members and residents as the data contained in this project does not include them. It is expected that the results of this research would reveal themes consistent with those found in the current recommendations.

One of the most prominent barriers facing social workers are regulations which dictate that a facility is not required to have a trained full-time social worker unless the facility contains 120 beds or more (OBRA 1987). As policy changers social workers can be the change factor that educates others on the importance of skilled and appropriate social work in skilled nursing facilities. Education specifically regarding social work in geriatrics is an area that is in need of strengthening to ensure that an understanding of developmental stages, family dynamics, grief and loss and dignity issues are fully understood. Understanding the role of family members is imperative when working in skilled nursing facilities as their involvement is critical too improving quality of life for residents (Choi, 1996).

Summary

The lack of collaboration to resolve quality of life issues between residents, family members, and facility staff creates an adversarial atmosphere in which no one’s needs are met. The data gathered in this study assisted in the creation of a handbook for
families. The handbook will utilize the strengths of each discipline including nursing, business, and social work to create an effective advocacy tool. The literature review provided an overview of various factors related to the impact in decision-making and advocacy within a skilled nursing facility. Business, nursing, and social work models are vastly different in their foundational aspects as well as their primary foci. These aspects are interrelated in patient advocacy yet are in such conflict that effective advocacy is seriously impaired. A collection of qualitative data, from each discipline previously researched in the literature review, provided information in which to create an advocacy handbook useful by numerous aspects of resident care. The researchers were unable to find a reasonable source of material in the discipline of social work, nursing or administration, which led to the current study. The research determined in part that clear communication and expectations between family and facility staff can provide the basis for positive interaction in years to come. Admission into long-term care can be a satisfying and agreeable situation that allows a loved one to be well cared for physically, psychologically, and emotionally.

More than twenty years have passed since the 1987 Nursing Home Reform Act that required across-the-board changes in federal standards to improve the quality of care in nursing homes but the problem continues as facilities phase in and out of compliance. It is the hope of the researchers that family members will utilize the handbook created to effectively advocate in a way that encourages participation, communication, and mutual respect. Only when these aspects are included will resident advocacy truly be about the resident.
APPENDIX A

Interview Questions
Interview Questions for the Qualitative Study

**Demographic Information**

1. Current position or title

2. Number of years in current position

3. Highest credential obtained

4. Highest level of education obtained

5. Prior type of employment (what field of work)

6. The most important reason that you chose your current position
If you are a facility employee answer all questions if not begin at question seven.

1. How many male residents are currently living in the facility? __________
2. How many female residents are currently living in the facility? __________
3. What is the total number of beds in the facility? __________
4. How many beds within the facility are Medicare certified? __________
5. How many beds within the facility are Medicaid certified? __________
6. Check if the facility is _______ for profit or ________ non-profit

7. Circle the three concerns that are most time consuming for you or facility staff to resolve with family members?

   Quality of Life Issues                      Accommodation of Personal Schedules
   Neglect Allegations                       Quality of Care Issues               Payment Issues
   Verbal/Emotional Abuse                    Resident/Resident Abuse              Theft/Loss

8. Circle the department(s) that is involved in Quality of Life concerns?

   Administration                           Activities                           Social Services
   Dietary                                   Nursing                              Medical Director
   Business Office                           Ombudsman                            Rehabilitation (OT/PT)
   Admissions                                Housekeeping                         Palliative Care Committee
9. Circle the department(s) that is involved completing the psychosocial portion of the Minimum Data Set (MDS)?

<table>
<thead>
<tr>
<th>Administration</th>
<th>Activities</th>
<th>Social Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dietary</td>
<td>Nursing</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Business Office</td>
<td>Rehabilitation (OT/PT)</td>
<td></td>
</tr>
<tr>
<td>Admissions</td>
<td>Housekeeping</td>
<td>Palliative Care Committee</td>
</tr>
</tbody>
</table>

10. Please circle the departments/persons who participate in resident care plan conferences.

<table>
<thead>
<tr>
<th>Administration</th>
<th>Activities</th>
<th>Social Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dietary</td>
<td>Nursing</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Business Office</td>
<td>Rehabilitation (OT/PT)</td>
<td>Family Members</td>
</tr>
<tr>
<td>Admissions</td>
<td>Housekeeping</td>
<td>Palliative Care Committee</td>
</tr>
<tr>
<td>Resident</td>
<td>Ombudsman</td>
<td></td>
</tr>
</tbody>
</table>

11. Circle the mechanism typically utilized in an attempt to resolve complaints by residents/family members?

<table>
<thead>
<tr>
<th>Administration</th>
<th>Department Heads</th>
<th>“In House” complaint form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ombudsman/DPH</td>
<td>Care Plan Conferences</td>
<td></td>
</tr>
</tbody>
</table>
12. How would you rank the importance of the following factors when determining appropriate roommates? (1= highest  6= lowest)

_________ Gender

_________ Level of Care/Infection Control

_________ Payer Source

_________ Cognition

_________ Behavior

_________ Resident Preference

13. Rank the practices utilized by staff to ensure resident privacy:

(1=most often  4=least often)

_________ Knock prior to entering room

_________ Privacy curtain closed while providing care

_________ Room door closed as requested by resident

_________ Protection of resident confidentiality while providing care or discussing resident needs

14. Would you consider changes in resident advocacy that may include a change in skilled nursing facility culture?

Yes  No
15. In general do you believe that families advocate in a way that is beneficial to their loved ones and the facility?

Yes      No

16. What recommendations would you make to family members on how to effectively advocate for their loved ones?

17. Please add any comments or information that you feel would be helpful in creating an effective advocacy handbook.
APPENDIX B

Consent To Participate In Research
CONSENT TO PARTICIPATE IN RESEARCH

You are invited to participate in a research study that will be conducted by Jose Ordaz and Renee Smith, Master of Social Work students at the Division of Social Work, California State University, Sacramento. This study will explore a collaborative approach to patient advocacy. The results will be compiled to create a handbook for family members. This project will include aspects of business, nursing, and social work in hopes of creating a handbook that will provide solutions that take into account each of the above mentioned disciplines, their goals and perspectives.

Procedures:

After reviewing this form and agreeing to participate, you will be provided with a survey. A time will be set up to retrieve your completed survey. This time will allow for any questions or comments that you may have regarding the research and/or survey. The survey, collection of results, and question and answer appointment should take less than 30 minutes. The survey is anonymous and no names will be recorded. Answers will be inputted into a research based program and surveys will then be destroyed. Color coding of surveys will allow data to be delineated to determine common themes of advocacy issues, strengths, and weaknesses.

As a participant in the study you can decide at any time not to answer a specific question or to rescind your agreement to participate.
Risks:
The study is considered to have minimal risk of harm or discomfort to the study participants, as the questions are not personal in nature. The questions are related professional work and daily activities in which participants have received educational and professional training. Participants who feel they are in need of emotional support in regards to this survey should contact:
San Joaquin County Mental Health
Stockton, CA 95202
Main Number: 209-468-8700
Crisis Number: 209-468-8686

Benefits:
The research gained by completing this survey may help others to understand the benefit or negative aspects to a collaborative approach to a social issue

Confidentiality:
All information is confidential and every effort will be made to protect your privacy. Your responses on the survey will be kept confidential. Information you provide on the consent form will be stored separately from the survey, and kept in a secure location at the researchers’ homes. The researchers’ thesis advisor will have access to the completed surveys for the duration of the project. The final research report will not include any identifying information. All of the data will be destroyed approximately one month after the project is filed with Graduate Studies at California State University, Sacramento, in June of 2010.
Compensation:

Participants will not receive any kind of fiscal compensation. However, upon completion of the research a summary of results will be offered to each participating facility.

Rights to withdraw:

If you decide to participate in this survey, you can withdraw at any point. At any time during the process you can elect not to answer any specific question.

I have read the descriptive information on the Research Participation cover letter. I understand that my participation is voluntary. My signature or initials indicate that I have received a copy of the Research Participation cover letter and I agree to participate in the study.

I, ________________________________, agree to be interviewed.

Signature or Initials: ___________________________ Date: _____________

If you have any questions you may contact the researcher:

Jose Ordaz

(###) ###-#### – Home
(###) ###-#### – Work
Email at #######.###

Renee Smith

(###) ###-####-Home
(###) ###-####-Work
Email at #####.###

If you need further information, you may contact the researcher’s thesis advisor:

Santos Torres
C/o California State University, Sacramento
(916) 278-7064
torres@csus.edu
APPENDIX C

Letters of Acknowledgement
Dr. Robin Carter, Director
Division of Social Work
6000 J Street
Sacramento, CA 95819

Dear Dr. Robin Carter,

MSW Intern, Jose Ordaz has been actively working with the San Joaquin County, Long-Term Care Ombudsman program to create the "Skilled Nursing Facilities Handbook for San Joaquin County" in collaboration with MSW Intern, Renee Smith. This handbook has been reviewed by many individuals who have found the information contained to be most useful and helpful to anyone who may be looking for or who currently has a family member placed in a skilled nursing facility.

We will produce this handbook as a working document to be used by our program and agency to share with anyone who may benefit from its contents. The handbook has basic information regarding care needs and services as well as references to useful laws and regulations.

If you have any further questions regarding this document, please contact me at the information listed below.

Sincerely,

Jill Hernandez
San Joaquin County
Long-Term Care Ombudsman Coordinator
P.O. Box 201056
Stockton, CA 95201
(209) 468-3788
(209) 932-2641 fax
jillhernandez@sjgov.org
Dr. Robin Carter  
Division of Social Work  
6000 J Street  
Sacramento, CA 95819

Dear Dr. Carter:

Jose Ordaz has been under my supervision while completing his MSW Intern hours with the San Joaquin County Ombudsman Program.

In completing his Master project, he created a Skilled Nursing Facilities Handbook in collaboration with MSW Intern Renee Smith. Our department is excited about the opportunity to work with Jose and Renee to publish it through our department as a public service and information source to people in the community in need of this kind of information.

It is currently being reviewed by the Ombudsman Volunteers and others in the department. Our goal is to have the booklets available at our upcoming Information Event in May.

We feel that the information in the book is extremely valuable and not readily available. This will be a great service and resource for our community.

If there are questions regarding our process or intentions, please contact me at 209-468-1374 or by e-mail. Thank you for your support and guidance on this project.

Respectfully,

Annette DePauli, MSW  
Social Services Supervisor  
Aging and Community Services  
P.O. Box 201056  
Stockton, CA 95201  
209-468-1374  
adepauli@sjgov.org
REFERENCES


Cutler, D. (Spring, 2005), Walking the Tightrope on Medicare Reform. The Journal of Economic Perspectives, 90, 45-56.


