

The Family Guide to New York Nursing Homes

What to expect, who does what, and how to handle the problems that arise



Care plans, the medical chart and what the records show

Who's who on staff, and whom to call

Falls, bedsores, weight loss, restraints and sedating drugs

Discharge, visiting and complaint rights

Checklists, an incident log and a contacts sheet

Free. Please read it, print it, and share it with anyone who has a loved one in a nursing home.

Read this first

Every year, thousands of New York families place a parent, spouse or relative in a nursing home. Most arrive knowing very little about how a nursing home works, who is responsible for what, or what the law requires. That gap matters. Families who know what to look for catch problems early, ask the right questions, and get them fixed.

This guide explains, in plain English, what happens inside a New York nursing home and what you can do when something goes wrong. We recommend that **every family read it**, ideally before or soon after admission.

How to use this guide

- **Part 1** covers admission and the first 30 days.
- **Parts 2 and 3** explain the staff, the care plan and the medical chart.
- **Part 4** covers common problems and the rules that protect residents.
- **Part 5** gives you a step-by-step plan, a quick-reference chart, and forms to tear out and use.

Each chapter begins with a short answer. Where it helps, chapters end with “the rules behind this,” listing the federal and New York regulations involved. You can bring those citations to a care plan meeting or a complaint.

Keep these numbers handy

Emergency or crime	911
NYS Department of Health nursing home complaint hotline	1-888-201-4563
Long Term Care Ombudsman	1-855-582-6769
Free review of a concern, Leitner Warywoda PLLC	(855) 585-2969

This guide provides general information about New York and federal nursing home rules as of the edition date. It is not legal or medical advice, and reading it does not create an attorney-client relationship. Rules change; check the current version at rightsforvictims.com/family-guide. The New York Nursing Home Resource Center is sponsored by Leitner Warywoda PLLC, 44 Elm Street, Suite 19, Huntington, NY 11743, (855) 585-2969. **Attorney Advertising.** Prior results do not guarantee a similar outcome.

Contents

Part 1. Getting started	5
1 The first 30 days: a checklist for families	6
2 What should I know before signing the admission agreement?	7
3 Health care proxy, MOLST and DNR: what do they mean in a New York nursing home?	8
Part 2. Who's who in the nursing home	10
4 Who's who in a nursing home? Staff titles and roles explained	11
5 What does a CNA do in a nursing home?	13
6 RN, LPN and charge nurse: what is the difference in a nursing home?	14
7 What does the director of nursing (DON) do in a nursing home?	15
8 What does a nursing home administrator do?	16
9 What does a nursing home social worker do?	17
10 Who is the doctor in a nursing home, and how often must a resident be seen?	18
11 How many staff must a New York nursing home have?	19
Part 3. The care plan and the chart	21
12 What is a nursing home care plan?	22
13 What happens at a nursing home care plan meeting, and how do I prepare?	24
14 What is the MDS (Minimum Data Set) in a nursing home?	25
15 What's in a nursing home chart? A guide to the medical record	26
16 What is a MAR and TAR in a nursing home?	28
17 What are ADL flow sheets and CNA documentation?	29
18 What is the Braden Scale for pressure sore risk?	30
19 Why do staff ask me to leave during changing, and how can I check for bedsores?	31
20 Bed sore stages explained: what do stage 1, 2, 3 and 4 mean?	33
Part 4. Safety, rights and common problems	35
21 When must a nursing home notify the family?	36
22 What should happen after a fall in a nursing home?	37
23 How much weight loss in a nursing home is too much?	38
24 What is a restraint in a nursing home?	39
25 Are bed rails allowed in nursing homes?	40
26 Is my loved one being overmedicated? Antipsychotics in nursing homes	41
27 What are the visiting rules in New York nursing homes?	42
28 Can a nursing home kick out a resident? Discharge rights in New York	43
29 How do I make a complaint inside the nursing home?	44

Part 5. Strategies and tools	45
30 When something goes wrong: a step-by-step plan	46
31 Common problems at a glance	48
32 Getting the medical records	49
33 When should a family talk to a lawyer?	49
34 Every-visit checklist	51
35 Incident and conversation log	52
36 Important contacts	53
37 Glossary of terms and abbreviations	54



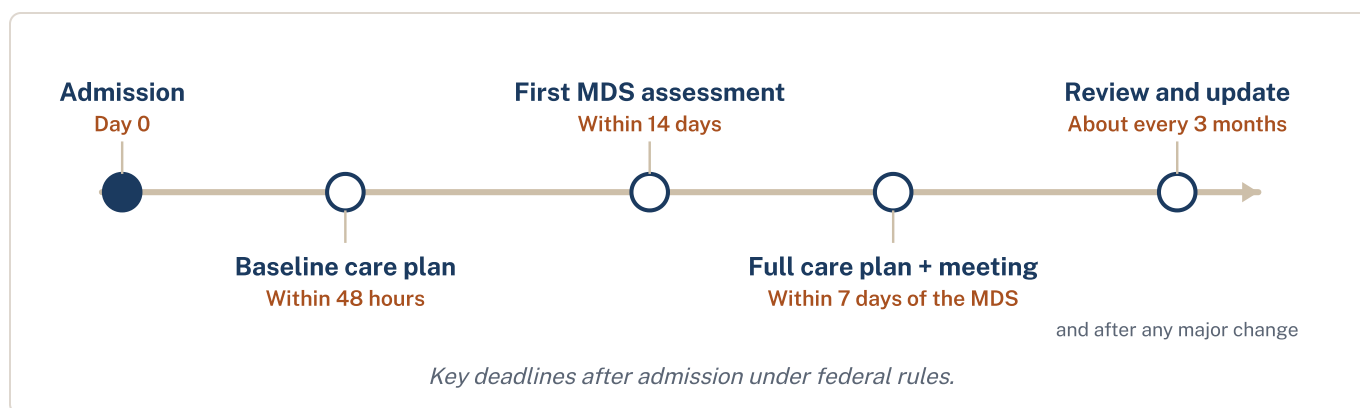
PART 1

Getting started

The first weeks in a nursing home set the pattern for everything that follows. This part covers what to do at admission and the legal documents that decide who can speak for the resident.

- 1 The first 30 days: a checklist for families
- 2 What should I know before signing the admission agreement?
- 3 Health care proxy, MOLST and DNR: what do they mean in a New York nursing home?

The first 30 days: a checklist for families



Most problems that become serious later can be traced to the first few weeks: a care plan that was never finished, a risk no one noticed, or a family that did not yet know whom to call. Use this checklist to get off on the right footing.

Before or on admission day

- ☐ Bring copies of the **health care proxy**, power of attorney, MOLST or living will, and any guardianship papers. Give copies to the social worker and ask that they be placed in the chart.
- ☐ Bring the hospital discharge papers and a **current medication list**. Ask the admitting nurse to compare them with the new orders.
- ☐ Read the **admission agreement** before signing (see the next chapter). You do not have to sign an arbitration agreement, and you cannot be required to personally guarantee payment.
- ☐ Tell the nurse about anything the hospital may have missed: falls at home, swallowing trouble, skin problems, hearing or vision loss, dentures, behaviors, and what calms or upsets your loved one.
- ☐ Label clothing, glasses, hearing aids and dentures. Ask for the personal property inventory sheet and keep a copy.

The first week

- ☐ Ask for a copy of the **baseline care plan**, which must be done within 48 hours of admission.
- ☐ Meet the unit manager or charge nurse, the social worker and, if you can, the Director of Nursing. Write their names and numbers on the contacts sheet at the back of this guide.
- ☐ Ask how many nursing assistants work the unit on days, evenings and nights, and how many residents each one cares for.
- ☐ Look at the skin with staff during care, especially the tailbone, hips and heels. A pressure injury can start within days.

- ☐ Confirm that the facility has your phone number and knows you want to be called about any fall, injury, new medication or change in condition.

Weeks two through four

- ☐ The first full assessment (the MDS) is due within 14 days. The comprehensive care plan follows within 7 days after that. Ask for the date of the first **care plan meeting** and attend.
- ☐ Visit at different times, including evenings, weekends and mealtimes. Problems often show up when staffing is thinnest.
- ☐ Ask for the resident's weight each week for the first month. Early weight loss is common and easy to miss.
- ☐ Start a simple log of what you see and whom you speak with. The incident log at the back of this guide works well.



CHAPTER 2

What should I know before signing the admission agreement?

THE SHORT ANSWER

The admission agreement is a contract. Read it before signing, ask for a copy, and do not sign anything you do not understand. Federal rules say a nursing home cannot make an arbitration agreement a condition of admission, and cannot require a family member to personally guarantee payment.

Arbitration agreements

Many admission packets include an agreement to send any future dispute, including a claim of neglect or abuse, to private arbitration instead of court. Under federal rules for Medicare and Medicaid facilities:

- Signing it cannot be required for admission or to keep receiving care.
- The agreement must say so, in plain language.
- You have the right to cancel (rescind) it within 30 calendar days of signing.

You may simply decline to sign. If you already signed and are within 30 days, cancel it in writing and keep a copy.

Payment guarantees

A facility may ask a family member who has legal access to the resident's money to use that money to pay the bill. It may not require a third party to personally guarantee payment as a condition of admission.

If you sign as "responsible party," read exactly what you are agreeing to.

Other things to look for

- Charges that are not covered by Medicare or Medicaid, and how they are billed.
- The bed-hold policy if the resident goes to the hospital.
- Any waiver of liability for lost property or injuries. Facilities cannot ask residents to give up their rights.



CHAPTER 3

Health care proxy, MOLST and DNR: what do they mean in a New York nursing home?

THE SHORT ANSWER

A health care proxy names an agent to make medical decisions if the resident cannot. A MOLST (Medical Orders for Life-Sustaining Treatment) is a New York form, signed by a practitioner, that turns the resident's wishes about CPR, hospitalization, feeding tubes and other treatment into medical orders the staff must follow. If there is no proxy, New York's Family Health Care Decisions Act lets a family member act as surrogate in a set order of priority.

The documents

- **Health care proxy.** Signed by the resident while able, naming a health care agent. The agent's authority begins when the resident is determined to lack capacity. The agent is entitled to the medical information needed to make decisions.
- **MOLST.** A bright pink New York form that records decisions about CPR, intubation, hospital transfer, artificial nutrition and other treatment as medical orders. It should be reviewed periodically and when the resident's condition changes.
- **DNR (do not resuscitate).** An order not to attempt CPR. In nursing homes it usually appears on the MOLST. A DNR does not mean "do not treat"; the resident is still entitled to all other care.
- **Living will.** A written statement of the resident's wishes, which guides the agent and the team.
- **Surrogate.** If there is no proxy and no guardian, the Family Health Care Decisions Act sets an order of priority (generally a guardian, then a spouse or domestic partner, an adult child, a parent, a sibling and a close friend).

What families should check

- Is a copy of the health care proxy in the chart, and does the facility have the agent's correct phone number?

- Does the MOLST reflect what the resident actually wanted, and was it discussed with the resident or agent?
- Was the MOLST reviewed after a hospital stay or major decline?

A power of attorney is different. It covers finances, not medical decisions. See [does a power of attorney help](#).

The rules behind this

New York Public Health Law art. 29-C (health care proxy)

New York Public Health Law art. 29-CC (Family Health Care Decisions Act)

42 C.F.R. § 483.10(g)(12) (advance directives)



PART 2

Who's who in the nursing home

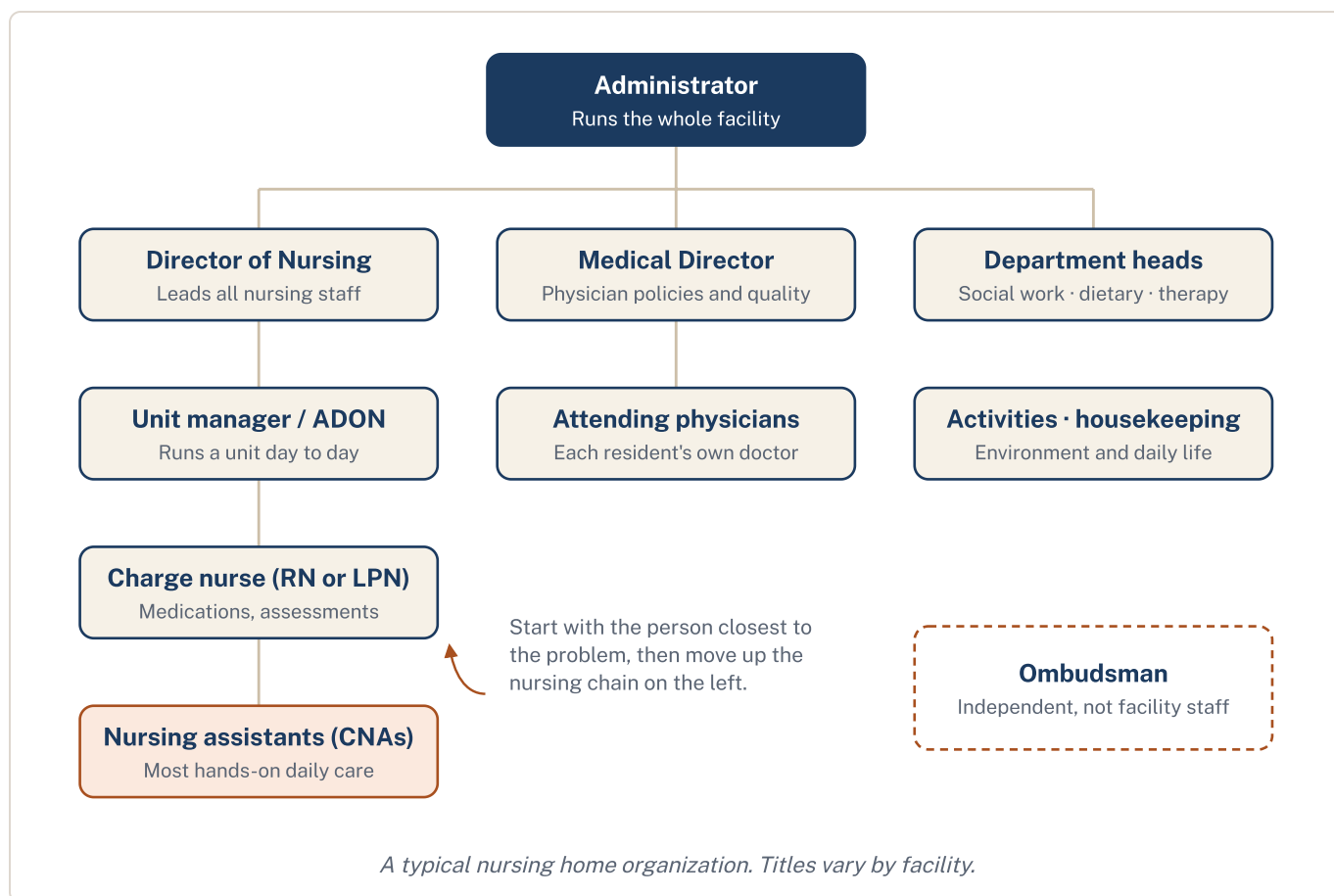
Knowing who does what tells you whom to ask, whom to call when something goes wrong, and who is responsible for fixing it.

- 4 Who's who in a nursing home? Staff titles and roles explained
- 5 What does a CNA do in a nursing home?
- 6 RN, LPN and charge nurse: what is the difference in a nursing home?
- 7 What does the director of nursing (DON) do in a nursing home?
- 8 What does a nursing home administrator do?
- 9 What does a nursing home social worker do?
- 10 Who is the doctor in a nursing home, and how often must a resident be seen?
- 11 How many staff must a New York nursing home have?

Who's who in a nursing home? Staff titles and roles explained

THE SHORT ANSWER

A nursing home is run by a licensed administrator. Nursing care is directed by the director of nursing, a registered nurse, and delivered by registered nurses (RNs), licensed practical nurses (LPNs) and certified nursing assistants (CNAs), who give most hands-on care. A medical director and attending physicians oversee medical care. Social workers, dietitians, therapists, activities staff and an infection preventionist round out the team.



Leadership

- **Administrator:** licensed by New York State; runs the whole facility, including budget, staffing levels and compliance. The person to escalate to when nursing leadership does not fix a problem.
- **Director of nursing (DON):** a registered nurse in charge of all nursing care and nursing staff.
- **Assistant director of nursing (ADON):** supports the DON, often responsible for staffing, education or specific units.
- **Medical director:** a physician responsible for the facility's medical care policies.

Nursing staff on the unit

- **Unit manager or nurse manager:** an RN who oversees one unit or floor. Usually the best first contact for a specific concern.
- **Nursing supervisor:** an RN in charge of the building on evenings, nights and weekends.
- **Charge nurse, RN or LPN:** gives medications and treatments, assesses residents and supervises the nursing assistants on the shift.
- **Certified nursing assistant (CNA):** provides most hands-on care: bathing, dressing, feeding, toileting, turning and transfers.
- **Wound care nurse:** in many facilities, a nurse with special training who assesses and treats pressure injuries.
- **MDS coordinator:** a nurse who completes the federally required [assessments](#).
- **Infection preventionist:** responsible for the infection control program; required by federal rules.

Other professionals

- **Social worker:** admission, discharge planning, family communication, grievances and emotional needs.
- **Dietitian:** assesses nutrition and weight loss and recommends supplements and diet changes.
- **Physical, occupational and speech therapists:** rehabilitation, mobility, safe transfers and swallowing (speech therapists evaluate choking and aspiration risk).
- **Activities director:** recreation and engagement programs.
- **Attending physician, nurse practitioner or physician assistant:** the resident's medical provider.

Not facility staff

The **Long Term Care Ombudsman** is an independent advocate for residents, reachable at 1-855-582-6769. Ombudsmen do not work for the facility.

Who to call about what

- Day-to-day care: the charge nurse, then the unit manager
- A pattern of problems or a serious event: the director of nursing
- Staffing, unresolved complaints or threats of discharge: the administrator
- Meetings, family communication or discharge: the social worker
- Medical decisions and medication changes: the attending physician or nurse practitioner

The rules behind this

42 C.F.R. § 483.35 (nursing services)

42 C.F.R. § 483.70 (administration)

CHAPTER 5

What does a CNA do in a nursing home?

THE SHORT ANSWER

A certified nursing assistant (CNA) provides most of the hands-on care a nursing home resident receives: bathing, dressing, grooming, help with eating and drinking, toileting and incontinence care, turning and repositioning, transfers and walking, and taking vital signs. CNAs work under the supervision of nurses and are usually the first to notice changes such as new redness, poor appetite or confusion.

Typical duties

- Bathing, dressing, oral care and grooming
- Helping residents eat and drink, and recording how much was eaten
- Toileting, incontinence care and changing
- Turning and repositioning bedbound residents to prevent pressure injuries
- Transfers from bed to chair and help with walking, using lifts where required
- Taking vital signs and weights
- Answering call bells
- Reporting changes in condition to the nurse
- Documenting care on flow sheets

What CNAs generally may not do

CNAs generally do not give medications, perform wound treatments or make clinical assessments. Those are nursing duties. If a CNA reports a problem, a nurse is responsible for assessing it and acting.

Training and certification

Federal rules require nurse aides to complete a state-approved training program of at least 75 hours, including supervised clinical training, and to pass a competency evaluation. A facility may not use someone as a nurse aide for more than four months unless the aide has completed training and is competent. New York maintains a Nurse Aide Registry where certification can be checked.

Why this matters

When a facility is short-staffed, the CNAs feel it first: each aide has more residents, and turning, toileting and feeding help get skipped. New York requires a minimum amount of CNA care time per resident each day. See [New York nursing home staffing requirements](#).

Tips for families

- Learn the names of the CNAs who care for your loved one on each shift.
 - Ask how many residents each aide is assigned on days, evenings and nights.
 - Tell the nurse, not only the aide, about any concern, so it is assessed and documented.
-

The rules behind this

42 C.F.R. § 483.35(d) (nurse aide requirements)

42 C.F.R. § 483.152 (nurse aide training programs)



CHAPTER 6

RN, LPN and charge nurse: what is the difference in a nursing home?

THE SHORT ANSWER

A registered nurse (RN) has the broadest training and is responsible for assessing residents, care planning and supervising. A licensed practical nurse (LPN) works under the direction of an RN or physician and typically gives medications and treatments. The charge nurse is whichever licensed nurse is in charge of a unit on a given shift. Many nursing home units are run day to day by LPNs, with an RN supervisor covering the building.

Registered nurse (RN)

- Performs and is accountable for nursing assessments
- Coordinates the MDS and care plans
- Assesses changes in condition and calls the physician
- Often serves as unit manager, supervisor or director of nursing

Federal rules require an RN on duty at least eight consecutive hours a day, seven days a week.

Licensed practical nurse (LPN)

- Gives medications and treatments, documented on the MAR and TAR
- Monitors residents and reports changes
- Often serves as charge nurse and supervises the CNAs on a unit

Charge nurse

Federal rules require a licensed nurse to serve as charge nurse on each shift. The charge nurse is the first person to ask about how a resident is doing that day, about medications, and about anything a CNA has

reported.

Why it matters

When a resident has a change in condition, such as a fall, fever, new confusion, a new wound or not eating, a nurse must assess the resident and notify the physician and family. Ask who assessed the resident and what was done.

The rules behind this

42 C.F.R. § 483.35(a)–(b) (nursing staff, charge nurse and RN coverage)



CHAPTER 7

What does the director of nursing (DON) do in a nursing home?

THE SHORT ANSWER

The director of nursing (DON) is the registered nurse responsible for all nursing care in the facility. The DON oversees the nurses and nursing assistants, nursing policies, staffing schedules, training and the quality of resident care. Federal rules require every nursing home to have a full-time RN as director of nursing.

Responsibilities

- Supervising RNs, LPNs and CNAs, usually through unit managers and supervisors
- Nursing policies and procedures, such as fall prevention, skin care, incontinence care and medication administration
- Nurse staffing schedules and assignments
- Staff training and competency
- Reviewing incidents, falls, pressure injuries, infections and complaints about nursing care
- Working with the administrator and medical director on quality improvement

When to contact the DON

Start with the charge nurse or unit manager for day-to-day issues. Go to the DON when a problem repeats, when the unit does not fix it, or when something serious happens: a fall with injury, a new pressure injury, an unexplained bruise or fracture, a medication error, or signs of abuse. Put your concern in writing (an email is fine) and ask for a written response.

Related roles

- **Assistant director of nursing (ADON)** supports the DON.
 - **Unit managers** run individual floors.
 - **Nursing supervisors** are in charge of the building on evenings, nights and weekends, when the DON is usually not there.
-

The rules behind this

42 C.F.R. § 483.35(b) (registered nurse and director of nursing)



CHAPTER 8

What does a nursing home administrator do?

THE SHORT ANSWER

The nursing home administrator is the licensed manager responsible for running the entire facility: operations, budget, staffing levels, hiring, policies, regulatory compliance and responding to inspections and complaints. In New York the administrator must hold a state nursing home administrator license. The administrator answers to the facility's owners or governing body.

Responsibilities

- Day-to-day management of every department: nursing, dietary, housekeeping, maintenance, social work, activities and admissions
- Budget and staffing levels, including use of agency staff
- Compliance with federal and New York regulations, including responding to Department of Health inspections
- Making sure allegations of abuse, neglect and injuries of unknown origin are reported to the state and investigated
- The grievance process and responses to family concerns

When to go to the administrator

- When the director of nursing has not resolved a serious or repeated problem
- Staffing concerns, such as too few aides on nights and weekends
- A threatened transfer or discharge
- Billing and admission agreement issues
- Suspected abuse or neglect, along with a report to the Department of Health

Put the concern in writing and keep a copy. If the administrator does not act, file a complaint with the Department of Health.

The rules behind this

42 C.F.R. § 483.70 (administration)

42 C.F.R. § 483.12(c) (reporting alleged violations)

CHAPTER 9

What does a nursing home social worker do?

THE SHORT ANSWER

The social worker (often called "social services") helps residents and families with the non-medical side of nursing home life: admission, scheduling care plan meetings, family communication, emotional and behavioral needs, roommate issues, missing belongings, benefits such as Medicaid, grievances and discharge planning. Facilities with more than 120 beds must employ a qualified social worker full time.

What social services does

- Helps with admission paperwork and adjustment to the facility
- Schedules and often leads care plan meetings
- Serves as a point of contact between the family and the care team
- Addresses mood, behavior and psychosocial needs, and arranges mental health services
- Handles complaints about lost items, roommate conflicts and dignity concerns
- Often serves as, or works with, the facility's grievance official
- Plans safe discharges home or to another setting

What social services does not do

The social worker does not direct nursing care. Concerns about falls, wounds, medications or hands-on care should go to nursing (the unit manager or [director of nursing](#)), with a copy to the social worker.

Tips

- Ask the social worker to send you the date of every care plan meeting in writing.
- Send a short written summary after each meeting.
- If the facility starts talking about discharge, ask the social worker for the written notice and the appeal rights. See [discharge rights](#).

The rules behind this

42 C.F.R. § 483.40(d) (medically related social services)

42 C.F.R. § 483.70(p) (social worker requirement)

CHAPTER 10

Who is the doctor in a nursing home, and how often must a resident be seen?

THE SHORT ANSWER

Every resident has an attending physician, who may be assisted by a nurse practitioner or physician assistant. Federal rules require a physician visit at least every 30 days for the first 90 days after admission and at least every 60 days after that, with some visits allowed to alternate with an NP or PA. Separately, each facility has a medical director who oversees medical care policies.

Attending physician

- Writes the orders for medications, diet and treatment
- Reviews the resident's overall plan of care
- Must be notified of significant changes in condition
- Residents have the right to choose their attending physician, subject to the facility's credentialing requirements.

How often visits happen

- Every 30 days for the first 90 days after admission
- At least every 60 days after that
- After the initial visit, required visits may alternate between the physician and a nurse practitioner or physician assistant

Many residents are actually seen more often by a nurse practitioner. Ask who the resident's provider is and how to reach them.

Medical director

The medical director is a physician responsible for implementing resident care policies and coordinating medical care in the facility. The medical director is not usually each resident's personal doctor, but is a person to involve when medical care problems are systemic.

Tips

- Ask for the attending's name and the best way to schedule a call.
 - Ask to be called before any new psychotropic medication is started.
 - Ask that the physician attend, or give input to, the care plan meeting.
-

The rules behind this

42 C.F.R. § 483.30 (physician services)

42 C.F.R. § 483.70(h) (medical director)

42 C.F.R. § 483.10(d) (choice of attending physician)



CHAPTER 11

How many staff must a New York nursing home have?

THE SHORT ANSWER

New York law requires nursing homes to provide an average of at least 3.5 hours of direct nursing care per resident per day, with at least 2.2 hours from certified nursing assistants and at least 1.1 hours from licensed nurses (RNs and LPNs). Federal rules also require an RN on duty at least eight hours a day, seven days a week, a licensed charge nurse on every shift, and enough staff to meet every resident's needs.

The rules

- **New York minimums:** 3.5 hours of care per resident per day, including 2.2 hours of CNA care and 1.1 hours of licensed nurse care.
- **Federal requirements:** sufficient staff with the right skills to meet each resident's needs, an RN at least eight consecutive hours a day, seven days a week, a full-time director of nursing, and a licensed charge nurse on each shift.

The minimum is a floor, not a target. A unit with many residents who need two-person transfers, feeding help or frequent turning may need far more.

How to check staffing

- **Read the posted staffing.** Nursing homes must post daily nurse staffing numbers at the start of each shift, in a place residents and visitors can see. Facilities must keep these postings for at least 18 months.
- **Check the staffing rating** for any facility in our directory. It is based on payroll data the facility reports to Medicare.
- **Visit at different times**, including evenings and weekends, when staffing is usually thinnest.

- **Ask how many residents each CNA is assigned** on days, evenings and nights.

Signs of understaffing

- Call bells ringing for a long time
 - Residents left in bed, in wet briefs or in the same position for hours
 - Meal trays left untouched for residents who need feeding help
 - Heavy use of agency staff who do not know the residents
 - Repeated falls and new pressure injuries on the unit
-

The rules behind this

New York Public Health Law § 2895-b

10 NYCRR § 415.13

42 C.F.R. § 483.35 (nursing services and posted staffing data)



PART 3

The care plan and the chart

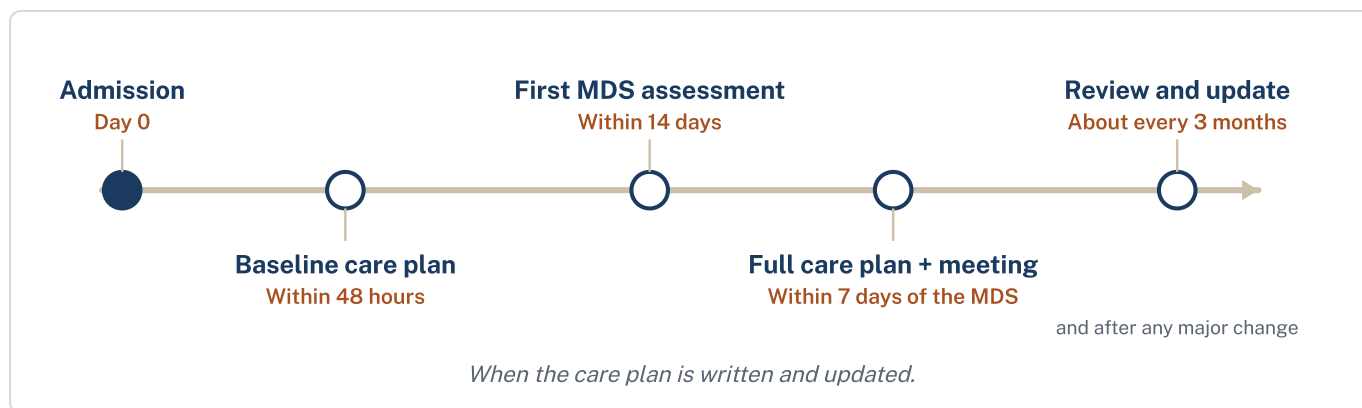
The care plan says what the facility promised to do. The chart shows what it says it did. Families who understand both can spot problems early.

- 12 What is a nursing home care plan?
- 13 What happens at a nursing home care plan meeting, and how do I prepare?
- 14 What is the MDS (Minimum Data Set) in a nursing home?
- 15 What's in a nursing home chart? A guide to the medical record
- 16 What is a MAR and TAR in a nursing home?
- 17 What are ADL flow sheets and CNA documentation?
- 18 What is the Braden Scale for pressure sore risk?
- 19 Why do staff ask me to leave during changing, and how can I check for bedsores?
- 20 Bed sore stages explained: what do stage 1, 2, 3 and 4 mean?

What is a nursing home care plan?

THE SHORT ANSWER

A care plan is the facility's written plan for how it will meet a resident's needs. It lists each problem or risk (such as falls, pressure sores, weight loss or confusion), a goal for each one, and the specific steps staff must take. Federal rules require a starter plan within 48 hours of admission and a full plan shortly after the first full assessment, and the resident and family have the right to help write it.



What a care plan contains

A care plan is organized by problem. For each one you should see:

- **The problem or risk**, for example "at risk for falls due to weakness and dementia" or "at risk for pressure injury."
- **A measurable goal**, such as "will have no falls with injury this quarter" or "skin will remain intact."
- **Interventions**: the specific things staff must do. Good interventions are concrete: "turn and reposition at least every two hours," "bed in lowest position with floor mats," "offer fluids every shift," "two-person assist for transfers."
- **Who is responsible** (nursing, the nursing assistants, dietary, therapy, social work) and when the plan will be reviewed.

When it is written and updated

- **Within 48 hours of admission**, a baseline care plan covering immediate needs such as medications, diet and safety.
- **Within 7 days after the first comprehensive assessment** (the MDS, which is due within 14 days of admission), the full care plan.
- **After every later assessment**, usually about every three months, and whenever the resident's condition changes significantly, such as after a fall, a hospital stay, a new wound or a big weight loss.

Your right to take part

Residents have the right to take part in planning their care, to choose who else attends, to see the care plan, and to have meetings scheduled when they and their family can attend. If the resident cannot participate, the health care agent, guardian or other representative steps in. See [how to prepare for a care plan meeting](#).

How to tell whether the plan is being followed

A care plan only matters if staff carry it out. Compare what the plan says with what you see. If the plan calls for a pressure-relieving mattress, heel protectors, a bed alarm or two-person transfers, look for them. If the plan says "encourage fluids" but the water pitcher is always full and out of reach, raise it.

The records show whether interventions were documented: the [nursing assistant flow sheets](#), the [medication and treatment records](#), and the nursing notes. Gaps between the plan and those records are often the first sign of neglect.

Red flags

- The same generic plan for every problem ("monitor," "encourage," "as needed") with no specific steps.
- The plan was not updated after a fall, a new wound, a hospital stay or major weight loss.
- No one has invited you to a care plan meeting in months.
- Staff on the floor do not know what the plan says.

The rules behind this

42 C.F.R. § 483.21 (baseline and comprehensive care plans)

42 C.F.R. § 483.10(c)(2) (right to participate in care planning)

10 NYCRR Part 415

CHAPTER 13

What happens at a nursing home care plan meeting, and how do I prepare?

THE SHORT ANSWER

A care plan meeting is a sit-down with the team that cares for the resident, usually nursing, social work, dietary, therapy and activities, to review how the resident is doing and update the care plan. It is typically held after each assessment, about every three months, and after major changes.

Residents and their representatives have the right to attend and to ask that it be scheduled at a time they can make.

Who attends

The team (often called the "interdisciplinary team" or "IDT") must include the attending physician, a registered nurse responsible for the resident, a nursing assistant responsible for the resident, and a member of the food and nutrition staff, plus others as needed such as social work, therapy and activities. In practice the physician and the nursing assistant are often missing. You can ask that they attend or that their input be provided.

How often

Most facilities hold a meeting after each scheduled assessment, which is roughly every three months, plus after a significant change in condition. You can ask for a meeting at any time if you have concerns. You can also ask to attend by phone or video.

How to prepare

- Ask for a copy of the current care plan before the meeting. Read it and mark anything that does not match what you see.
- Write down dates and specifics: weight changes, falls, bruises, missed meals, soiled bedding, call bells not answered.
- Bring the resident if he or she wants to attend, and anyone else the resident wants there.

Questions to ask

- What is the current weight, and how does it compare to one, three and six months ago?
- Is there any skin breakdown or redness anywhere? What was the latest skin assessment and Braden score?
- How many falls have there been since the last meeting, and what changed in the plan after each one?

- What medications were started or changed, and why? Is the resident on any antipsychotic or sedating medication?
- How much of each meal is the resident eating, and how much fluid is the resident drinking?
- Who is the resident's regular nursing assistant on each shift?
- What exactly will be done differently before the next meeting, and who is responsible?

After the meeting

Send a short email or letter to the social worker summarizing what was agreed. That creates a record. If the agreed changes do not happen, raise it with the director of nursing, and if needed file a grievance or a complaint with the Department of Health.

The rules behind this

42 C.F.R. § 483.21(b)(2) (care plan team and timing)

42 C.F.R. § 483.10(c)(2) (right to participate and request meetings)



CHAPTER 14

What is the MDS (Minimum Data Set) in a nursing home?

THE SHORT ANSWER

The Minimum Data Set (MDS) is a detailed, standardized assessment that every Medicare- and Medicaid-certified nursing home must complete for each resident. It covers memory, mood, behavior, mobility, eating, continence, skin, falls and medications. It is done within 14 days of admission, reviewed at least every three months, redone yearly and redone after any significant change in condition. The care plan is built from it.

What it measures

The MDS is organized into sections, including cognition (often a short memory test called the BIMS), mood, behavior, ability to perform daily activities such as eating, toileting and walking, bladder and bowel continence, weight and nutrition, skin condition including pressure injuries, falls since the last assessment, and certain medications such as antipsychotics.

When it is done

- Within 14 days of admission
- A quarterly review at least every three months
- A full reassessment at least once a year
- Within 14 days after a significant change in condition, for better or worse

A registered nurse must conduct or coordinate each assessment. Many facilities employ an "MDS coordinator" for this.

Why it matters to families

- **It drives the care plan.** Problems identified on the MDS should appear in the care plan with specific interventions.
- **It shows decline over time.** Comparing MDS assessments shows changes in weight, mobility, continence and skin.
- **It feeds public ratings.** Medicare's quality measures for each facility, shown in our directory, are calculated largely from MDS data.
- **It should match the chart.** An MDS that reports no falls or no pressure injury when the nursing notes say otherwise is a serious documentation problem.

You can ask for copies of the MDS assessments as part of the resident's records. Our [records request kit](#) includes them.

The rules behind this

42 C.F.R. § 483.20 (resident assessment)

CHAPTER 15

What's in a nursing home chart? A guide to the medical record

THE SHORT ANSWER

A nursing home chart is made up of many separate records, most of them now electronic. The key parts are physician orders, physician and nursing progress notes, the medication and treatment administration records (MAR and TAR), nursing assistant flow sheets, the MDS assessments, care plans, skin and wound records, weights and intake records, fall and incident documentation, labs and hospital transfer forms.

The main parts

- **Physician orders.** Every medication, diet, treatment, test and precaution must be ordered. Telephone orders are written by a nurse and later signed by the practitioner.
- **Progress notes.** Notes by physicians, nurse practitioners, nurses, social workers, dietitians and therapists describing the resident's condition and events.
- **MAR and TAR.** The record of each medication dose and each treatment (such as a wound dressing) and whether it was given.

- **Nursing assistant flow sheets.** Shift-by-shift documentation of bathing, eating, toileting, incontinence care and repositioning.
- **MDS assessments and care plans.**
- **Skin and wound records.** Weekly skin checks, Braden Scale risk scores, and wound measurements, descriptions and photographs.
- **Weights, intake and output.** Weekly or monthly weights, the percentage of each meal eaten, and fluid intake.
- **Fall risk assessments and post-fall notes.** Note that the facility's internal incident report itself may be kept outside the chart.
- **Labs, x-rays and consultations,** and **hospital transfer forms** sent with the resident to the emergency room.
- **Admission documents,** including the admission agreement and any arbitration agreement, and advance directives such as a health care proxy or MOLST.

What families often miss

- **Electronic records have an audit trail** showing who entered or changed each entry and when. Late entries and edits made after an injury can matter.
- **Blanks are information.** A blank box on a flow sheet or MAR usually means the task was not documented, and often that it was not done.
- **"Charting by exception"** means some facilities only write a note when something is abnormal. Ask how the facility documents.

How to get the chart

Residents and their legal representatives have the right to see the record within 24 hours and get copies within two working days. After a death, the executor, administrator or a close family member can request the records. Our free kit generates the request letter.

The rules behind this

42 C.F.R. § 483.10(g)(2) (access to records)

42 C.F.R. § 483.70(i) (medical records)

New York Public Health Law § 18

What is a MAR and TAR in a nursing home?

THE SHORT ANSWER

The MAR, or medication administration record, lists every medication a resident is ordered and records each dose: the time, the nurse's initials, and a code if it was refused, held or not available. The TAR, or treatment administration record, does the same for treatments such as wound dressings, skin barrier creams, oxygen and special monitoring. Most nursing homes now keep both electronically (an eMAR and eTAR).

How to read them

- Each row is one order: the drug or treatment, the dose, the route and how often.
- Each box is one scheduled administration. Initials mean the nurse documented giving it.
- Codes or circled entries explain exceptions, such as "refused," "held," "resident out of facility" or "drug not available." The reason should be explained in a note.
- "PRN" means "as needed." For PRN pain or anxiety medications, the nurse should document why it was given and whether it worked.

What to look for

- **Blanks.** An empty box means the dose or treatment was not documented.
- **Repeated "not available" codes,** which can mean the pharmacy delivery failed.
- **Wound treatments on the TAR that do not match the wound notes,** such as a dressing ordered daily but documented only a few times a week.
- **Frequent PRN sedatives or antipsychotics,** especially in the evening. See antipsychotics and chemical restraints.
- **New medications started without notice to the family,** particularly psychotropic drugs.

Federal rules require each facility to keep its medication error rate below 5 percent and to ensure residents are free of significant medication errors.

The rules behind this

42 C.F.R. § 483.45 (pharmacy services and unnecessary drugs)

42 C.F.R. § 483.45(f) (medication error rates)

What are ADL flow sheets and CNA documentation?

THE SHORT ANSWER

ADL flow sheets (also called CNA documentation or "point of care" records) are where nursing assistants record the hands-on care they give each shift: bathing, dressing, eating and how much of each meal was eaten, toileting and incontinence care, transfers, walking and turning and repositioning. They are usually entered on a kiosk or tablet. They are often the best evidence of whether basic care was actually given.

What they record

- "ADLs" are activities of daily living: bathing, dressing, eating, toileting, transferring and moving in bed.
- For each, the aide documents how much help was needed (independent, supervision, one-person or two-person assist).
- Meal intake is usually recorded as a percentage of each meal eaten.
- Repositioning and incontinence checks may be recorded each time or once per shift, depending on the facility.

Why they matter

Pressure injuries, dehydration and weight loss usually develop when basic care is missed. Flow sheets show whether a resident at risk for bedsores was actually turned, whether a resident who needs feeding help was actually fed, and whether incontinence care was done. Compare them with the [care plan](#): if the plan says "turn every two hours" and the flow sheet shows one entry per shift, that is a gap.

Warning signs in the records

- Blank shifts, especially nights and weekends
- Identical entries every shift, which can mean "copy-forward" charting
- Entries documented when the resident was in the hospital
- Meal intake consistently below 50 percent with no dietitian follow-up

Staffing assignment sheets show which aide was responsible for the resident on each shift. Those are generally not available through a records request, but can be obtained in litigation.

The rules behind this

42 C.F.R. § 483.24 (activities of daily living)

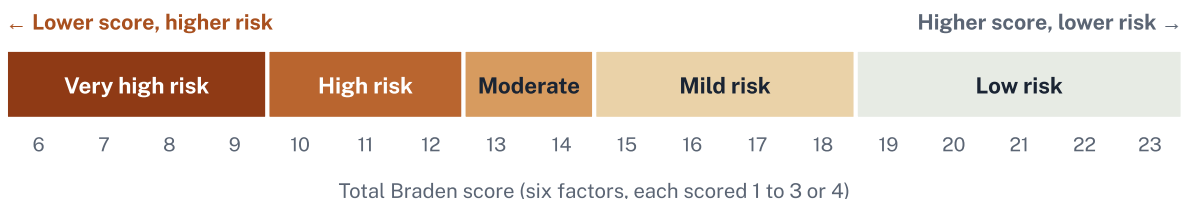
42 C.F.R. § 483.25(b)(1) (pressure ulcers)

CHAPTER 18

What is the Braden Scale for pressure sore risk?

THE SHORT ANSWER

The Braden Scale is a standard tool nurses use to estimate a resident's risk of developing a pressure injury (bedsore). It scores six factors: sensory perception, moisture, activity, mobility, nutrition, and friction and shear. Totals range from 6 to 23. Lower scores mean higher risk: generally 15 to 18 is mild risk, 13 to 14 moderate, 10 to 12 high and 9 or below very high.



Braden Scale risk levels. Any score of 18 or below calls for prevention steps in the care plan.

The six factors

- **Sensory perception:** can the resident feel and report discomfort?
- **Moisture:** how often is the skin wet from sweat or incontinence?
- **Activity:** is the resident bedbound, chairbound or walking?
- **Mobility:** can the resident change position without help?
- **Nutrition:** how well is the resident eating?
- **Friction and shear:** does the resident slide down in bed or the chair?

What should happen when the score is low

A risk score is only useful if it leads to action. For an at-risk resident, the [care plan](#) should include specific prevention steps, such as a pressure-redistributing mattress, a turning and repositioning schedule, heel protection or "floating" heels on a pillow, prompt incontinence care, barrier creams, and a dietitian review.

What to ask

- What is the current Braden score, and what was it on admission?
- When was it last reassessed? (It should be redone regularly and after any change in condition.)
- What prevention steps were added when the score dropped?

A falling Braden score with no change in the care plan, followed by a new wound, is a common pattern in pressure injury neglect cases.

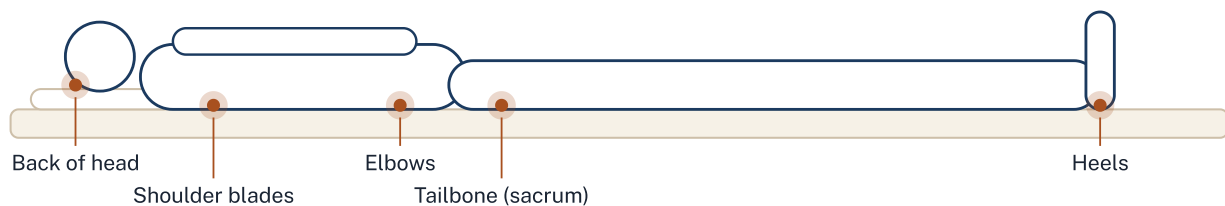
CHAPTER 19

Why do staff ask me to leave during changing, and how can I check for bedsores?

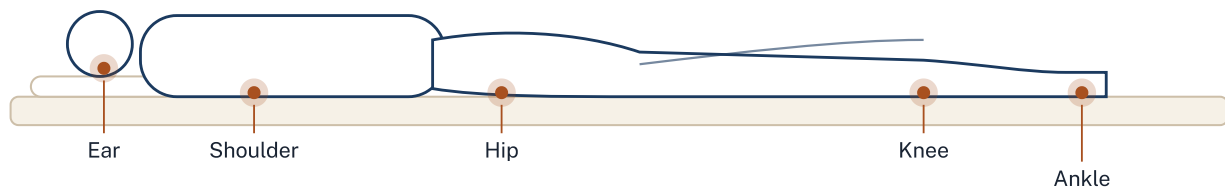
THE SHORT ANSWER

Staff usually ask visitors to step out during bathing and changing to protect the resident's privacy and dignity, and sometimes a roommate's. But privacy is the resident's right, not the facility's. If the resident wants you there, or you are the resident's legal representative and it is appropriate, you can ask to stay. Either way, you can ask the nurse for a skin check with you present, ask for the latest skin and wound records, and watch for warning signs.

Lying on the back



Lying on the side



Bony areas carry the most pressure. Check them during care.

Where pressure injuries most often form.

Why staff ask you to leave

- **The resident's privacy.** Residents have a right to privacy in personal care. Many residents prefer family not see them undressed.
- **A roommate's privacy,** if care is being given in a shared room.
- **Facility habit.** Sometimes "please step out" is simply routine, and sometimes it is used to avoid scrutiny.

When you can ask to stay

If the resident can make decisions and wants you present, the resident can say so. If the resident lacks capacity and you are the health care agent or guardian, you can ask to be present or to see the skin, keeping the resident's dignity in mind. Close the curtain and ask that the roommate's privacy be respected. If staff refuse, ask why in writing and raise it with the director of nursing.

Practical ways to check on the skin

- **Ask the nurse for a skin check while you are there.** A nurse can look at the high-risk areas (tailbone and buttocks, hips, heels, ankles, elbows, shoulder blades, back of the head and ears) and tell you what is seen.
- **Ask direct questions.** "Is there any open area, redness or dressing anywhere on her body?" is harder to deflect than "How is she doing?"
- **Ask for the latest weekly skin assessment, Braden score and any wound measurements.** Residents and their representatives have the right to see the records within 24 hours.
- **Attend care plan meetings** and ask about skin every time.

Warning signs you can see without undressing anyone

- A dressing on the heel, hip or lower back, or a new air mattress or heel boots that appeared without explanation
- A strong odor, or drainage on sheets or clothing
- Pain or wincing when the resident is moved or sits
- The resident left in the same position for hours, or in a wet brief
- Fever, new confusion or loss of appetite, which can signal an infected wound

Do not remove dressings yourself. If the resident agrees, photographs of a wound taken by family with a date can be useful later; avoid capturing other residents. The facility must notify the resident's representative of a significant change in condition, which includes a new or worsening pressure injury. See [bedsore stages explained](#).

The rules behind this

42 C.F.R. § 483.10(h) (privacy)

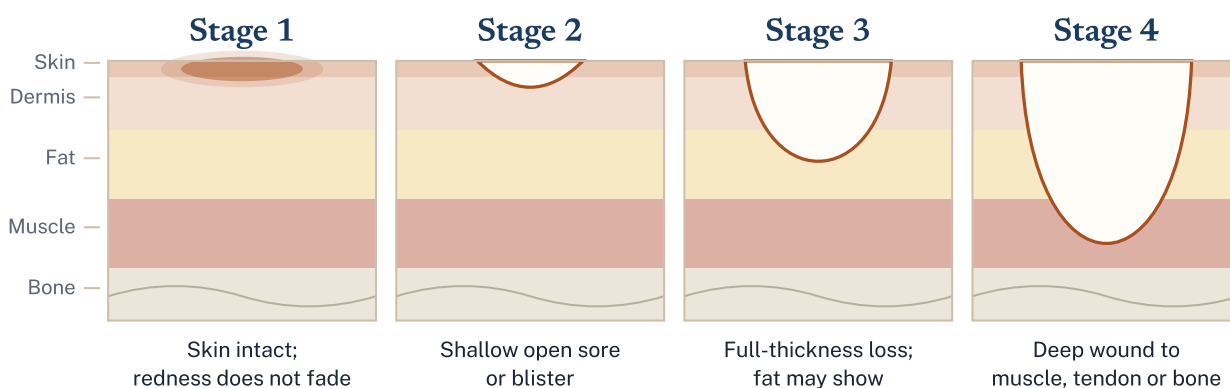
42 C.F.R. § 483.10(g)(2) (access to records)

42 C.F.R. § 483.25(b)(1) (pressure ulcers)

Bedsore stages explained: what do stage 1, 2, 3 and 4 mean?

THE SHORT ANSWER

Pressure injuries are staged by depth. Stage 1 is intact skin with a red area that does not fade when pressed. Stage 2 is a shallow open sore or blister. Stage 3 goes through the full thickness of the skin into fat. Stage 4 exposes muscle, tendon or bone. An unstageable wound is covered by dead tissue so its depth cannot be seen, and a deep tissue injury is a purple or maroon area of damage beneath intact skin.



Pressure injury stages, shown in cross-section. An injury covered by dead tissue that cannot be seen is called "unstageable."

The stages

- **Stage 1:** intact skin with a persistent red area (on darker skin, a color or texture change) that does not turn white when pressed.
- **Stage 2:** partial-thickness skin loss: a shallow open wound or an intact or broken blister.
- **Stage 3:** full-thickness skin loss with fat visible. There may be tunneling under the edges.
- **Stage 4:** full-thickness skin and tissue loss with exposed or palpable muscle, tendon, ligament, cartilage or bone. High risk of bone infection (osteomyelitis) and sepsis.
- **Unstageable:** the base is covered by slough (yellow, tan or gray) or eschar (black or brown), so the true depth cannot be seen. Once cleaned, these are usually stage 3 or 4.
- **Deep tissue pressure injury:** a persistent deep red, maroon or purple area, or a blood-filled blister, from damage to underlying tissue. These often open into deep wounds.

Where they form

Over bony areas that bear weight: the tailbone (sacrum and coccyx), buttocks, hips, heels, ankles, elbows, shoulder blades, and the back of the head and ears.

What the rules require

Federal rules require nursing homes to ensure that a resident does not develop a pressure injury unless the resident's condition made it clinically unavoidable, and that a resident with one receives the treatment needed to promote healing and prevent infection. The facility must document that it assessed risk and carried out prevention before claiming a wound was unavoidable.

Watch the progression

Wound records should show weekly measurements and descriptions. A wound that keeps getting larger or deeper, a stage 2 that becomes a stage 4, or a wound first documented at stage 3 or 4 (meaning earlier stages were missed) are serious warning signs.

The rules behind this

42 C.F.R. § 483.25(b)(1) (pressure ulcers)

10 NYCRR § 415.12

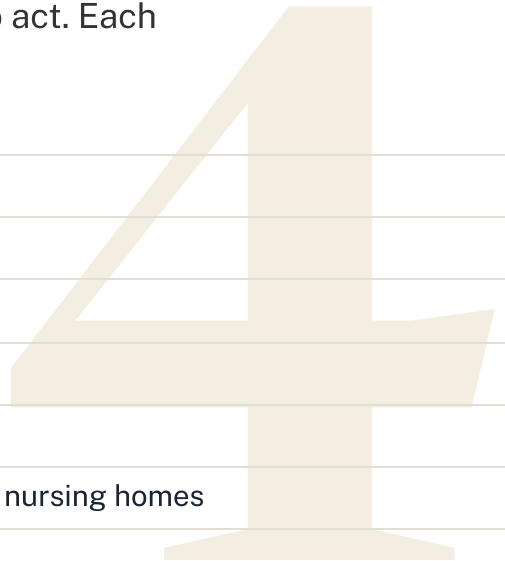


PART 4

Safety, rights and common problems

Falls, weight loss, restraints, sedating drugs, discharge notices and visiting limits are where families most often need to act. Each chapter explains the rules and what to do.

- 21 When must a nursing home notify the family?
- 22 What should happen after a fall in a nursing home?
- 23 How much weight loss in a nursing home is too much?
- 24 What is a restraint in a nursing home?
- 25 Are bed rails allowed in nursing homes?
- 26 Is my loved one being overmedicated? Antipsychotics in nursing homes
- 27 What are the visiting rules in New York nursing homes?
- 28 Can a nursing home kick out a resident? Discharge rights in New York
- 29 How do I make a complaint inside the nursing home?



When must a nursing home notify the family?

THE SHORT ANSWER

A nursing home must immediately inform the resident, consult the resident's physician, and notify the resident's representative (such as the health care agent or a designated family member) when there is an accident that results in injury and has the potential to require a doctor's intervention, a significant change in physical, mental or psychosocial condition, a need to change treatment significantly, or a decision to transfer or discharge the resident.

Events that should trigger a call

- A fall or other accident with injury
- A new or worsening pressure injury
- Significant weight loss, dehydration or stopping eating
- New confusion, fever, infection or breathing problems
- Starting or significantly changing a medication or treatment
- A transfer to the hospital or a plan to discharge

Make sure the facility can reach you

- Confirm in writing who the designated representative is and the best phone numbers.
- Ask that notifications be documented in the chart, including the time and who was called.

If you were not told

Late or missing notification is a common finding in Department of Health inspections. Ask for the nursing note documenting the notification. If you learned of an injury or wound on your own, write down when and how, and raise it with the director of nursing.

The rules behind this

42 C.F.R. § 483.10(g)(14) (notification of changes)

What should happen after a fall in a nursing home?

THE SHORT ANSWER

After a fall, a nurse should immediately assess the resident for injury, including neurological checks if the resident hit his or her head or the fall was unwitnessed; notify the physician and the family; obtain any needed x-rays or hospital care; investigate how and why the fall happened; and update the care plan with new interventions to prevent another fall. Unexplained injuries such as a fracture with no known cause must be reported to the state.

What the facility should do

- Assess for pain, injury and range of motion before moving the resident
- Monitor neurological signs after a head strike or unwitnessed fall, especially for residents on blood thinners
- Notify the physician and the resident's representative
- Investigate the cause: footwear, lighting, a wet floor, a call bell out of reach, medication changes, an unanswered call for help, or a missing alarm or mat
- Update the fall risk assessment and the care plan

Questions to ask

- Was the fall witnessed? Where and when did it happen, and who found the resident?
- Was the resident supposed to have assistance, an alarm, a low bed or floor mats? Were they in place?
- How many falls has the resident had, and what changed after each one?
- Was the resident on any new medication?

Fractures and head injuries

Hip fractures and brain bleeds are among the most serious nursing home injuries. A fracture with no explanation, or bruising in unusual places, is an "injury of unknown origin" that the facility must report to the state and investigate. Facilities must report alleged abuse or serious bodily injury within two hours, and other alleged violations within 24 hours.

The rules behind this

42 C.F.R. § 483.25(d) (accidents and supervision)

42 C.F.R. § 483.12(c) (reporting and investigating)

How much weight loss in a nursing home is too much?

THE SHORT ANSWER

Nursing homes generally treat as significant a weight loss of 5 percent in 30 days, 7.5 percent in 90 days or 10 percent in 180 days. Significant loss should trigger reweighing to confirm, a dietitian and physician review, a look for causes such as dental problems, swallowing difficulty, depression or lack of feeding help, and changes to the care plan. Facilities must help each resident keep acceptable body weight and stay hydrated unless the resident's condition makes that impossible.

Warning signs

- Loose clothing or dentures, sunken cheeks
- Meal trays left untouched or set out of reach
- Dry mouth, cracked lips, dark urine, new confusion or repeated urinary infections (signs of dehydration)
- A resident who needs help eating but is not being helped

What should happen

- Regular weights (weekly after admission or a significant change, then usually monthly)
- Recording the percentage of each meal eaten
- A dietitian assessment, supplements, and help or cueing at meals
- A speech therapy swallowing evaluation for coughing or choking at meals
- Notice to the physician and family

Questions to ask

- What is the current weight, and what was it one, three and six months ago?
- Who helps the resident eat at each meal?
- When did the dietitian last see the resident, and what changed?

The rules behind this

42 C.F.R. § 483.25(g) (nutrition and hydration)

42 C.F.R. § 483.60 (food and nutrition services)

What is a restraint in a nursing home?

THE SHORT ANSWER

A physical restraint is anything attached to or near a resident's body that the resident cannot easily remove and that limits movement or access to the body, such as a vest, lap belt, tray table or tucked sheets, and sometimes bed rails or a chair the resident cannot get out of. A chemical restraint is a drug used for discipline or staff convenience rather than to treat a medical symptom. Residents have the right to be free from both, except when required to treat a medical symptom.

Physical restraints

Whether something is a restraint depends on its effect on the resident, not its name. Common examples:

- Vests, belts and wrist ties
- Lap trays or tables the resident cannot remove
- Chairs that tilt back or are placed so the resident cannot get up
- Sheets tucked so tightly the resident cannot move
- Bed rails that keep a resident from getting out of bed voluntarily

Chemical restraints

A medication becomes a chemical restraint when it is used to make a resident easier to manage rather than to treat a diagnosed condition. Antipsychotics and sedatives given to calm "behaviors" are the most common concern. See [antipsychotics in nursing homes](#).

When restraints are allowed

Only when needed to treat a specific medical symptom, after less restrictive alternatives have been tried, for the shortest time possible, with the resident's or representative's informed consent and regular reassessment. Staff convenience and short staffing are never valid reasons.

Why restraints are dangerous

Restraints do not reliably prevent falls. They can cause strangulation and entrapment, pressure injuries, muscle loss, incontinence, agitation and depression.

What families can do

- Ask what medical symptom the restraint is treating and what alternatives were tried.

- Ask to see the order, the assessment and the consent.
- Raise it at the [care plan meeting](#), and file a grievance or Department of Health complaint if the restraint continues without justification.

The rules behind this

42 C.F.R. § 483.10(e)(1) (right to be free from restraints)

42 C.F.R. § 483.12(a)(2)

10 NYCRR Part 415



CHAPTER 25

Are bed rails allowed in nursing homes?

THE SHORT ANSWER

Bed rails are allowed only under conditions. Before installing them, a nursing home must try appropriate alternatives, assess the resident for the risk of entrapment, review the risks and benefits with the resident or representative and get informed consent, and make sure the bed and rails fit and are maintained. Rails that keep a resident from getting out of bed can also count as a restraint.

The dangers

Residents can become trapped between the rail and the mattress, between split rails, or between the rail and the headboard, which can cause suffocation, strangulation and death. Residents also climb over rails and fall from a greater height.

What the facility must do

- Try alternatives first, such as a low bed, floor mats, a concave or bolstered mattress, or more frequent checks
- Assess the resident's entrapment risk
- Explain risks and benefits and obtain informed consent
- Make sure the rails, mattress and bed frame are compatible and properly installed, and inspect them regularly

What to look for

- Gaps between the mattress and the rail large enough for an arm, head or chest
- A mattress that is too small for the frame, or an air mattress that compresses at the edge
- A resident who tries to climb over the rails

If you see an entrapment risk, report it to the nurse in writing immediately.

The rules behind this

42 C.F.R. § 483.25(n) (bed rails)

CHAPTER 26

Is my loved one being overmedicated? Antipsychotics in nursing homes

THE SHORT ANSWER

Antipsychotic drugs such as quetiapine (Seroquel), risperidone (Risperdal), olanzapine (Zyprexa) and haloperidol (Haldol) carry an FDA boxed warning of increased risk of death in elderly people with dementia. Federal rules allow psychotropic drugs only when needed to treat a specific, documented condition, require attempts to reduce the dose, and limit "as needed" orders to 14 days unless the prescriber documents why a longer order is appropriate.

Signs of overmedication

- Sudden or excessive sleepiness, or the resident "not like herself"
- New falls, unsteadiness or shuffling
- Drooling, stiffness or tremors
- Poor appetite, weight loss or trouble swallowing
- Withdrawal and loss of interest

What the rules require

- A psychotropic drug may be given only if necessary to treat a specific condition diagnosed and documented in the record.
- The facility must attempt gradual dose reductions and use behavioral approaches, unless clinically contraindicated.
- "As needed" (PRN) psychotropic orders are limited to 14 days unless the prescriber documents the rationale; PRN antipsychotics require a new evaluation to renew.
- Residents may not receive unnecessary drugs, including drugs in excessive doses, for excessive duration or without adequate monitoring.

Questions to ask

- What diagnosis is this medication treating, and who prescribed it?
- What non-drug approaches were tried first?

- When is the next attempt to reduce the dose?
- Why was I not told before it was started?

Check the [MAR](#) for how often PRN sedatives are actually given. Each facility's antipsychotic use rate is a Medicare quality measure.

The rules behind this

42 C.F.R. § 483.45(d)–(e) (unnecessary and psychotropic drugs)

42 C.F.R. § 483.10(e)(1) (chemical restraints)

CHAPTER 27

What are the visiting rules in New York nursing homes?

THE SHORT ANSWER

Residents have the right to receive the visitors they choose at the time they choose, subject to the resident's own wishes and reasonable clinical or safety restrictions. Immediate family and the resident's representative must have access at any time, subject to the resident's consent. A facility may not limit visits as punishment for complaints.

What the facility can and cannot do

- **Can:** apply reasonable limits needed for clinical care, infection control or other residents' safety and privacy, and limit a specific visitor who is abusive or a danger.
- **Cannot:** impose arbitrary visiting hours on family, or restrict a family member because the family has complained.

Why visits matter

Regular, unannounced visits at different times of day are one of the best protections a resident has. Families notice weight loss, poor hygiene, unanswered call bells and changes in mood that the chart may not show.

If a facility restricts your visits, ask for the reason in writing, contact the Ombudsman and consider a complaint to the Department of Health.

The rules behind this

42 C.F.R. § 483.10(f)(4) (visitation)

Can a nursing home kick out a resident? Discharge rights in New York

THE SHORT ANSWER

A nursing home may transfer or discharge a resident against the resident's wishes only for limited reasons: the facility cannot meet the resident's needs, the resident's health has improved, the resident endangers the safety or health of others, the resident has failed to pay after notice, or the facility is closing. The facility generally must give 30 days' written notice explaining the reason and the right to appeal, and in most cases cannot discharge the resident while an appeal is pending.

The notice

A discharge notice must be in writing, state the reason and effective date, say where the resident will go, explain how to appeal, and give contact information for the Long Term Care Ombudsman. A copy must go to the Ombudsman. Shorter notice is allowed only in limited situations, such as an emergency or when the resident has been in the facility less than 30 days.

What to do

- Ask for the notice in writing if you only got a verbal warning.
- Appeal right away, following the instructions in the notice. In New York, appeals are heard by the Department of Health.
- Call the Ombudsman at 1-855-582-6769.
- Be cautious about "hospital dumping": a facility refusing to readmit a resident after a hospital stay. Residents generally have the right to return to the facility after hospitalization.

Discharge as retaliation

A discharge threat that follows family complaints is a red flag. Residents and families may voice grievances without reprisal.

The rules behind this

42 C.F.R. § 483.15 (admission, transfer and discharge)

10 NYCRR § 415.3

CHAPTER 29

How do I make a complaint inside the nursing home?

THE SHORT ANSWER

Every nursing home must have a grievance policy and a grievance official responsible for handling complaints. You can file a grievance orally or in writing; writing is better. The facility must investigate, take corrective action, and give a written decision. Filing a grievance with the facility does not stop you from complaining to the Department of Health or the Ombudsman at the same time.

How to file

- Ask for the name of the grievance official (often the social worker or administrator).
- Put the complaint in writing: what happened, when, who was involved and what you want done.
- Keep a copy and note the date you delivered it.
- Ask for a written decision.

What the facility must do

- Investigate promptly and take action to prevent further problems while it investigates
- Report allegations of abuse, neglect, exploitation or injuries of unknown origin to the state
- Give a written decision that summarizes the complaint, the findings and the corrective action
- Not retaliate against the resident or the family

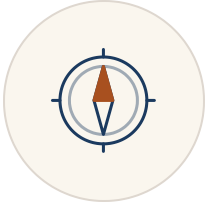
When to go outside the facility

For abuse, serious injury, or a problem the facility does not fix, [file a complaint with the New York State Department of Health \(1-888-201-4563\)](#) and contact the Ombudsman (1-855-582-6769). Ask for any grievances about the resident and the facility's written responses as part of the [records request](#).

The rules behind this

42 C.F.R. § 483.10(j) (grievances)

42 C.F.R. § 483.12(c) (reporting)



PART 5

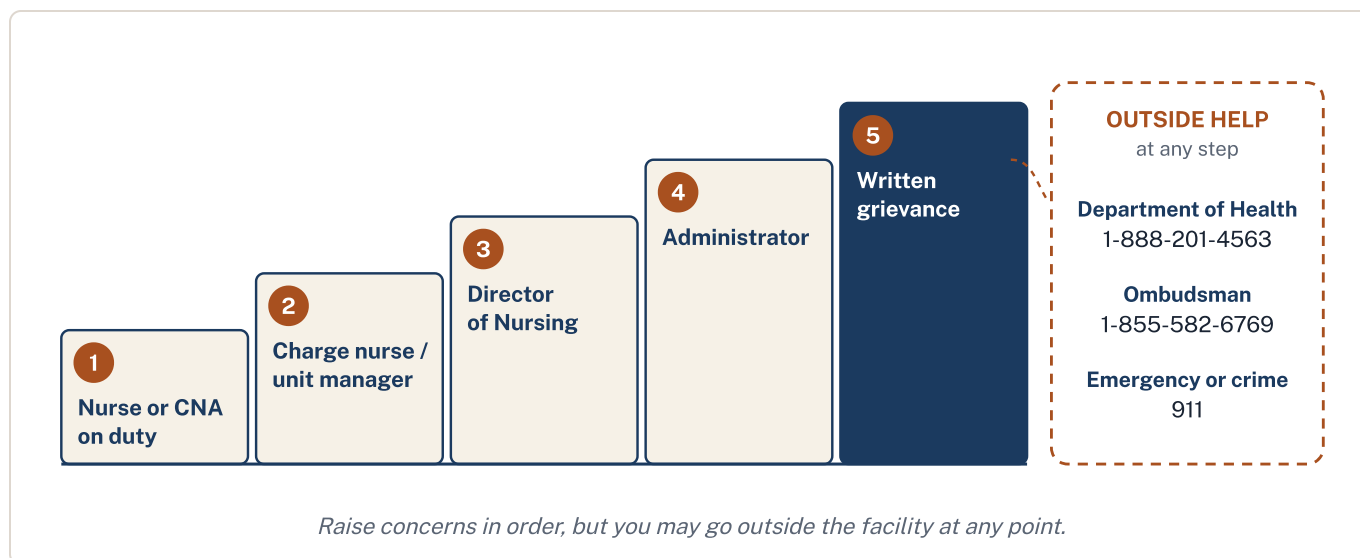
Strategies and tools

A step-by-step plan for when something goes wrong, a quick-reference chart of common problems, and forms you can tear out and use.

- 30 When something goes wrong: a step-by-step plan
- 31 Common problems at a glance
- 32 Getting the medical records
- 33 When should a family talk to a lawyer?
- 34 Every-visit checklist
- 35 Incident and conversation log
- 36 Important contacts
- 37 Glossary of terms and abbreviations



When something goes wrong: a step-by-step plan



When you see a problem, it is natural to feel angry or unsure whom to tell. A calm, organized approach gets faster results and protects your loved one if the problem turns out to be serious.

Step 1. Make sure your loved one is safe

If there is an emergency, a serious injury, or you believe a crime has occurred, call 911. Otherwise, ask the nurse on duty to assess the resident now and to call the doctor. Ask what the doctor ordered.

Step 2. Write it down

- Note the date, time, what you saw or were told, and the names and titles of the staff involved.
- If you have authority to act for the resident, photographs of an injury, a wound or conditions in the room can be very helpful. Respect roommates' privacy.
- After an important conversation, send a short email or letter: "To confirm our conversation today..." Keep copies of everything.

Step 3. Go up the ladder

Start with the person closest to the problem and move up if it is not fixed.

1. **The nursing assistant or nurse on duty** for day-to-day care.
2. **The charge nurse or unit manager** when the problem continues or involves a nursing assessment.
3. **The Director of Nursing** for repeated problems, injuries, staffing or skin breakdown.
4. **The Administrator** when nursing leadership does not fix it.

5. **A written grievance** to the facility's grievance official. The facility must investigate and give you a written decision.

Step 4. Go outside the facility when you need to

You do not have to finish the steps above first. For abuse, a serious injury, or a problem that keeps happening:

- **New York State Department of Health** nursing home complaint hotline: **1-888-201-4563**.
- **Long Term Care Ombudsman**, an independent advocate for residents: **1-855-582-6769**.
- **Police (911)** for assault, sexual abuse or theft. The New York Attorney General's Medicaid Fraud Control Unit also investigates abuse and neglect in nursing homes.

Step 5. Get the records

The chart shows what the facility documented and what it did not. See "Getting the medical records" in this part.

Step 6. Know when to get legal advice

If the resident suffered a serious injury, a severe pressure injury, a fracture, major weight loss, an infection that led to sepsis, abuse, or an unexpected death, speak with a lawyer early. Deadlines can be short, and evidence such as video and staffing records may be overwritten.

Common problems at a glance

Use this chart when something does not look right. Each row points to the chapter that explains the rules and what to ask.

Problem	Warning signs	What to do first	Read
Bedsore (pressure injuries)	Redness that does not fade, blisters, open areas on the tailbone, hips or heels; odor; resident left in one position	Ask the nurse to look now; ask for the wound measurements, the Braden score and the turning schedule	Ch. 20
Falls	New bruises, pain, a new limp, a resident found on the floor, an alarm or mat that is missing	Ask whether the doctor and family were notified, what caused it, and what the care plan now requires	Ch. 22
Weight loss or dehydration	Loose clothes, uneaten trays, water out of reach, dry mouth, dark urine, new confusion	Ask for the weight record and intake records; ask for a dietitian review	Ch. 23
Sudden confusion or sleepiness	A change from the resident's usual self over hours or days	Treat it as a change in condition; ask about infection, new drugs and a doctor's evaluation	Ch. 21
New sedating or antipsychotic drug	Drowsiness, falls, withdrawal, drooling, stiffness	Ask what the drug is for, who consented, and the plan to reduce it	Ch. 26
Restraints or bed rails	Belts, trays, chairs the resident cannot leave, rails raised on both sides	Ask for the assessment, the medical reason and the consent form	Ch. 24
Unexplained injury or possible abuse	Bruises, fractures, fear of a staff member, torn clothing, withdrawal	Report it to the Administrator in writing and to the Department of Health; call 911 for a crime	Ch. 29
Family not told	You learn of a fall, hospital trip or new drug after the fact	Remind the facility in writing that you are the contact to be notified	Ch. 21
Call bells not answered	Long waits, a resident left wet or soiled, missed meals	Note times and dates; ask about staffing on that shift; take it to the Director of Nursing	Ch. 11
Discharge or transfer notice	A notice that the resident must leave, or a refusal to readmit after a hospital stay	Do not move the resident; read the notice, appeal, and call the Ombudsman	Ch. 28
Visits restricted	Limits on hours or on who may visit	Ask for the reason in writing; contact the Ombudsman	Ch. 27

CHAPTER 32

Getting the medical records



THE SHORT ANSWER

A resident, or the person legally authorized to act for the resident, has the right to see the nursing home records within 24 hours of asking (excluding weekends and holidays) and to receive copies within two working days. After a death, the estate's representative can request them.

Who can ask

- The resident.
- The health care agent, guardian or other legal representative, when the resident cannot act.
- After a death, the executor or administrator of the estate. A family member without those papers may still be able to obtain records in some situations.

What to ask for

Ask for the **complete** record, not a summary: nursing notes, care plans, MDS assessments, medication and treatment records, nursing assistant flow sheets, wound records and photographs, weight records, incident reports and physician orders. Ask for electronic records in electronic form.

A free kit to help

Our free Records Request Kit includes a request letter, instructions and the forms families most often need. It is at rightsforvictims.com/nursing-home-records.

CHAPTER 33

When should a family talk to a lawyer?

Most concerns can and should be raised with the facility first. But some situations call for legal advice right away, because the facility's records, video and staffing information may not be kept for long, and

legal deadlines may be running.

Situations that warrant a call

- A stage 3 or stage 4 pressure injury, or an "unstageable" wound
- A fall that caused a fracture, a head injury or a hospital stay
- Significant weight loss or dehydration that required hospital care
- An infection that led to sepsis
- Abuse, sexual abuse, or an injury no one can explain
- A wandering incident or an unsupervised exit from the building
- A death that was unexpected or followed any of the above

Deadlines

New York sets strict time limits for injury and wrongful death claims. Claims involving a county- or city-run nursing home can require a formal notice within as little as 90 days. Do not wait to find out whether a deadline applies.

What to bring

Your log or notes, any photographs, letters and emails with the facility, the admission agreement, discharge papers, and any records you have already received.

Every-visit checklist

Take a minute on each visit to look at the same things. Small changes are easiest to fix when they are caught early.



Comfort and care

- ☐ Fresh water within reach; resident able to drink it
- ☐ Clean, dry, and dressed; no odor of urine or stool
- ☐ Hair, nails, mouth and dentures cleaned
- ☐ Glasses, hearing aids and dentures in place
- ☐ Meal tray eaten, or help given with eating
- ☐ Clothes fitting the same way (no new looseness)



Mind and mood

- ☐ Alert and acting like their usual self
- ☐ No new sleepiness, confusion, agitation or fear
- ☐ No signs of pain when moving
- ☐ Taking part in activities and meals with others



Skin and safety

- ☐ Repositioned since your last visit; not in the same spot for hours
- ☐ Heels off the mattress; cushions and special mattress in use
- ☐ No new bruises, skin tears, redness or bandages
- ☐ Call bell within reach; answered promptly
- ☐ Bed low, mats and alarms in place if the care plan calls for them
- ☐ Walker or wheelchair within reach and in good repair



Talk to staff

- ☐ Asked the nurse about any changes, new orders or new drugs
- ☐ Asked about falls, weight and skin since last visit
- ☐ Wrote down names and anything that needs follow-up

Incident and conversation log

Write things down as soon as you can. Keep this log with copies of any letters or emails.

Date / time	What I saw or was told	Staff involved (name, title)	Whom I told	What they said or did

Important contacts

Nursing home name and address

Unit / room number

Main phone and nursing station

Charge nurse or unit manager

Director of Nursing

Administrator

Social worker

Attending physician

Grievance official

Health care agent / representative

Outside help

Emergency or crime	911
NYS Department of Health nursing home complaints	1-888-201-4563
Long Term Care Ombudsman (independent advocate)	1-855-582-6769
Compare nursing homes, inspections and staffing	rightsforvictims.com/nursing-homes-ny
Free Records Request Kit	rightsforvictims.com/nursing-home-records
Free review of a concern (Leitner Warywoda PLLC)	(855) 585-2969

Glossary of terms and abbreviations

ADL

Activities of daily living: bathing, dressing, eating, toileting, moving and walking.

Baseline care plan

The first, short care plan, due within 48 hours of admission.

Braden Scale

A score used to measure a resident's risk of developing pressure injuries. Lower scores mean higher risk.

Care plan

The written plan listing each of the resident's problems, goals and the steps staff must take.

CMS

Centers for Medicare & Medicaid Services, the federal agency that sets nursing home rules.

CNA

Certified nursing assistant. Provides most hands-on care.

DNR

Do not resuscitate order.

DOH

New York State Department of Health, which licenses and inspects nursing homes.

DON

Director of Nursing. Leads the nursing department.

Flow sheet

Records where nursing assistants document care such as turning, toileting, bathing and meals.

Grievance

A complaint the facility must investigate and answer in writing.

Health care proxy

A document naming an agent to make health care decisions if the resident cannot.

IDT

Interdisciplinary team: nursing, social work, dietary, therapy, activities and the physician.

LPN

Licensed practical nurse.

MAR

Medication administration record, showing each dose given or missed.

MDS

Minimum Data Set, the standard federal assessment done at admission, quarterly and after major changes.

MOLST

Medical Orders for Life-Sustaining Treatment, New York's form for end-of-life treatment wishes.

Ombudsman

An independent advocate for residents who does not work for the facility.

PRN

"As needed," used for medications given only when a need arises.

Pressure injury

Damage to skin and tissue from pressure, also called a bedsore or pressure ulcer. Staged 1 through 4.

PT / OT / SLP

Physical therapy, occupational therapy, speech-language pathology.

RN

Registered nurse.

Statement of Deficiencies (Form 2567)

The inspection report listing a facility's violations, available on our directory pages.

TAR

Treatment administration record, showing wound care and other treatments.

24-hour report

A shift-to-shift report of residents with changes, falls or new problems.

Notes

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

You are not alone

If you are worried about the care someone you love is receiving, start with the steps in this guide. If the resident has been seriously hurt, or the facility will not fix the problem, a nursing home attorney can review what happened at no charge.

(855) 585-2969

Leitner Warywoda PLLC · 44 Elm Street, Suite 19, Huntington, NY 11743 ·
nylawinjury.com



More free resources at rightsforvictims.com

- Inspection, staffing and complaint history for every New York nursing home
- How to file a complaint with the Department of Health
- The Records Request Kit, with letters and forms
- The online Family Guide, updated as the rules change

Attorney Advertising. This guide is general information, not legal advice. October 2026 edition. © Leitner Warywoda PLLC. You may print and share this guide free of charge, unchanged and in full.