



The Ins and Outs of Long-Term Care Admission Agreements

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A Long-Term Care Facility Admission Agreement is, at its most basic level, a legal contract that describes the services the facility will provide to the resident in exchange for the rate the resident will pay to the facility. By signing the agreement, the resident agrees to all of the terms and conditions in the contract, whether or not the contract has been read or understood.

The admission agreement is important because it affects every aspect of the resident's life, including medical treatment, living quarters, and being discharged.

Many times, the resident, or his or her family, is under severe stress and time constraints when entering a facility. Some residents may not have loved ones to help them review the agreement. In addition, they may have vision, memory or other impairments that make it difficult to read and/or comprehend the agreement.

Many residents explain that they were told the contract is just “boilerplate” and contains “standard language,” by having it compared to an end-user agreement for an app on a phone.

Further, admissions staff at many facilities, oftentimes unintentionally, make verbal assurances to prospective residents that are not contained in the admission agreement. For example, we have had numerous clients be told by an admissions director at an assisted living facility that they can stay there until they die. In some occasions, the resident's health declines and his or her needs correspondingly increase, and the facility can no longer meet those needs. So, the resident needs to be moved to a skilled nursing facility.

Virtually every admission agreement has a clause that says the contract represents the entire agreement between the facility and the resident, and that all agreements, covenants, representations, and warranties, express or implied, oral or written, are contained within the agreement. Accordingly, any such verbal assurances are not enforceable by the resident.

But, because the agreement is what governs the residents' rights, it is critically important that they review it carefully. Today, we are hoping to identify some provisions that should be discussed with prospective residents.

1. Who Has the Authority to Sign and Admission Agreement?

- (a) The **resident**, provided they have capacity.

CAUTION: Depending on their licensing, some facilities may not admit residents with capacity issues if they are alone. DHS 89.29(i) states that no residential care apartment complex may admit any of the following individuals, unless the person being admitted shares an apartment with a competent spouse or other people who have legal responsibility for the individual who (a) is declared incompetent; (b) has an activated health care power of attorney; or (c) is found by a physician or psychologist to be incapable of recognizing danger, summoning assistance, expressing need, or making care decisions.

(b) A **fiduciary**. A fiduciary is a person or organization that is legally and ethically bound to act in the best interest of another person. They owe a duty of loyalty to that person, meaning they must put that person's interests ahead of their own and avoid conflicts of interest.



(1) An **agent under a financial power of attorney**. Section 244.43 (1) of the Wisconsin Statutes authorizes an agent to "contract with any person..."

(2) An **agent under an activated health care power of attorney**. Section 155.20(2)(c)2.c. of the Wisconsin Statutes states that a health care agent may consent to the admission to a nursing home or community based residential facility for purposes other than recuperative care if document specifically authorizes, and if principal is not diagnosed as developmentally disabled or as having a mental illness.

(3) A **guardian of the person**. Section 54.24(1)(b) of the Wisconsin Statutes provides that the guardian of the person has the “duty to secure any necessary care or services for the ward that are in the ward’s best interest.” Wis. Stat. § 54.25(2)(d)2 bestows upon the guardian:



- (A) Informed consent for social and supported living services;
- (B) Power to choose providers of medical, social, and supported living services;
- (C) Power to have custody of ward; and
- (D) Power to apply for protective placement

Further, Wis. Stat. § 55.055 grants the guardian the power to consent to the admission of a facility without a protective placement order if the facility has fewer than 16 beds, OR the stay is for 60 days or less; OR if the guardian pursues a protective placement order after admission for a stay exceeding 60 days.

(4) A **guardian of the estate**. Section 54.20(3)(b) of the Wisconsin Statutes authorizes the guardian of an estate to enter into a contract without specific court approval.

(5) **Someone other than the resident or his or her appointed fiduciary**, so long as the admission is for less than 60 days or is ultimately blessed by the court.

Section 50.06(3) of the Wisconsin Statutes designates a hierarchy of individuals who may consent to the admission to a facility on behalf of an incapacitated individual, who are, in order:

- (A) The incapacitated individual’s spouse or domestic partner;
- (B) The incapacitated individual’s adult son or daughter;
- (C) A parent of the incapacitated individual;
- (D) An adult brother or sister of the incapacitated individual;
- (E) A grandparent of the incapacitated individual;
- (F) An adult grandchild of the incapacitated individual; or
- (G) The incapacitated individual’s adult close friend.



This designated person can consent to the admission to a facility on behalf of an incapacitated individual, provided that:



(A) None of the other individuals in the same category as the designated person object;

(B) None of the individuals in a category who reside with the incapacitated individual object (with some qualifications);

(C) The incapacitated individual is not developmentally disabled or mentally ill;

(D) A petition for guardianship and protective placement has been filed;

(E) The incapacitated individual is not objecting; and

(F) The admission is for no longer than 60 days, or the court appoints a guardian, or the incapacitated individual is discharged, whichever occurs first.

(6) A **“Patient’s Representative”** without court approval. On March 20, 2026, Governor Evers signed into law Wisconsin Act 115, which contains our new ‘Patient Representative’ Legislation, otherwise known as the ‘Next of Kin’ law. The law went into effect on June 1.

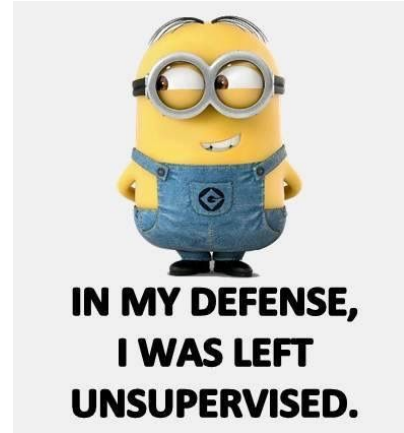
(A) **Finding of Incapacity.** Just like with a health care power of attorney, two health care providers must first find the patient is incapacitated. The two health care providers may include two physicians, or a physician and an advanced care clinician, which includes a psychologist, nurse practitioner, or physician’s assistant.

(B) **Appointment of a Patient’s Representative.** If the patient is incapacitated and does not have a health care power of attorney, or the health care power of attorney does not grant the agent the authority to admit the principal to a long-term care facility, a “Patient Representative” may be appointed to admit the patient from the hospital to the long-term care facility. The Patient Representative is identified based on the same list as stated above found in Section 50.06(3).

(C) **Signing a Declaration.** Once the Patient Representative is selected and the person identified agrees to serve, that person may make health care decisions for the incapacitated individual and to “authorize expenditures” from the patient’s assets to pay for the patient’s expenses at the long-term care facility.

(D) **No Judicial Oversight.**

Unlike an admission pursuant to 50.06, however, once selected, a Patient Representative is not subject to judicial oversight. Again, unlike a guardianship and protective placement order that is reviewed each year by the court to determine if it is still necessary, there is no such process for a Patient Representative.



2. What **must** be in the Admission Agreement.

(a) **Nursing Homes.** 42 CFR 483.15 states that “The facility must establish and implement an admissions policy.” Further, DHS § 132.31 contains the rights of residents of **nursing homes**. It states that every resident shall have the right to all of the following:

(1) **Admission Agreement.** To “be fully informed in writing, prior to or at the time of admission, of all services and the charges for these services, and be informed in writing, during the resident’s stay, of any changes in services available or in charges for services,” as follows:

(A) An accurate description of the basic services provided by the facility, the rate charged for those services, and the method of payment for them;

(B) Information about all additional services regularly offered but not included in the basic services. The facility shall provide information on where a statement of the fees charged for each of these services can be obtained. These additional services include pharmacy, x-ray, beautician, and all other additional services regularly offered to residents or arranged for residents by the facility;

(C) The method for notifying residents of a change in rates or fees;



(D) Terms for refunding advance payments in case of transfer, death or voluntary or involuntary discharge;

(E) Terms of holding and charging for a bed during a resident’s temporary absence;

(F) Conditions for involuntary discharge or transfer, including transfers within the facility;

(G) Information about the availability of storage space for personal effects; and

(H) A summary of residents’ rights recognized and protected by this section and all facility policies and regulations governing resident conduct and responsibilities.

(I) DHS § 132.31.2 states that “No statement of admission information may be in conflict with any part of this chapter.”

(2) **Non-Discrimination.** DHS § 132.31(p) holds that every resident has the right to “be free from discrimination based on the source from which the facility’s charges for the resident’s care are paid,” as follows:

(A) No facility may assign a resident to a particular wing or other distinct area of the facility, whether for sleeping, dining or any other purpose, on the basis of the source or amount of payment, except that a facility only part of which is certified for Medicare reimbursement under 42 USC 1395 is not prohibited from assigning a resident to the certified part of the facility because the source of payment for the resident’s care is Medicare.



(B) Facilities shall offer and provide an identical package of basic services meeting the requirements of this chapter to all individuals regardless of the sources of a resident’s payment or amount of payment. Facilities may offer enhancements of basic services, or enhancements of individual components of basic services, provided that these enhanced services are made available at an identical cost to all residents regardless of the source of a resident’s payment. A facility which elects to offer enhancements to basic services to its residents must provide all residents with a detailed explanation of enhanced services and the additional charges for these services pursuant to par. (d) 1. b.

(C) If a facility offers at extra charge additional services which are not covered by the medical assistance program under ss. 49.43 to 49.497, Stats., and chs. DHS 101 to 108, it shall provide them to any resident willing and able to pay for them, regardless of the source from which the resident pays the facility’s charges.

(D) No facility may require, offer or provide an identification tag for a resident or any other item which discloses the source from which the facility’s charges for that resident’s care are paid.

(E) 42 CFR 483.15(b)(1) also states that “A facility must establish, maintain and implement identical...provision of services for all individuals regardless of source of payment.”

MYTH: One of the biggest misunderstandings we run into with clients is the fear that if they receive Medicaid in a nursing home, they will receive inferior or reduced care. DHS § 132.31(p) clearly prohibits this. Medicaid recipients may not necessarily be able to stay in a private room, though, unless it is deemed medically necessary.

(3) **Explanation.** Facility staff shall verbally explain to each new resident and to that person’s guardian, if any, prior to or at the time of the person’s admission to the facility, these rights and the facility’s policies and regulations governing resident conduct and responsibilities.

(4) **Changes.** All amendments to the rights provided under this section and all amendments to the facility regulations and policies governing resident conduct and responsibilities require notification of each resident or guardian, if any, or any other responsible person designated in writing by the resident, at the time the amendment is put into effect. The facility shall provide the resident or guardian, if any, or any other responsible person designated in writing by the resident and each member of the facility's staff with a copy of all amendments.



(5) **Complaints.** Any person may file a complaint with a licensee or the department regarding the operation of a facility. Complaints may be made orally or in writing.

(b) **Community-based Residential Facilities.** DHS § 83.29 governs admissions agreements to **community-based residential facilities**. It states that “before or at the time of admission, the CBRF shall provide written information regarding services available and the charges for those services to each resident, including persons admitted for respite care, or the resident’s legal representative. This information shall include any charges for services not covered by the daily or monthly rate, any *entrance fees*, assessment fees and security deposit.”

An “entrance fee” is defined as a payment required for admission to the CBRF that is in addition to the fees for services and security deposit.

(1) **Admission Agreement.** “The admission agreement shall be given in writing and explained orally *in the language* of the prospective resident or legal representative. Admission is contingent on a person or that person’s legal representative signing and dating an admission agreement.” The admission agreement shall include all of the following:

(A) An accurate description of the basic services provided, the rate charged for those services and the method of payment;

(B) Information about all additional services offered, but not included in the basic services. The CBRF shall provide a written statement of the fees charged for each of these services;



(C) The method for notifying residents of a change in charges for services;

(D) Terms for resident notification to the CBRF of voluntary discharge;

(E) Terms for refunding charges for services paid in advance, entrance fees, or security deposits in the case of transfer, death or voluntary or involuntary discharge;

(F) A statement that the amount of the security deposit may not exceed one month's fees for services, if a security deposit is collected;

(G) Terms for holding and charging for a resident's room during a resident's temporary absence; and

(H) Reasons and notice requirements for involuntary discharge or transfer, including transfers within the CBRF.



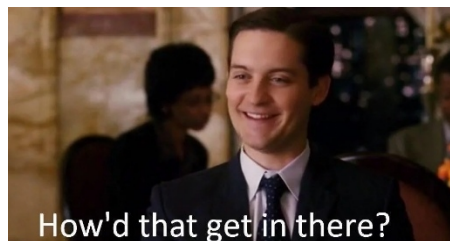
(2) **Refunds.** The CBRF shall return all refunds due a resident under the terms of the admission agreement within 30 days after the date of discharge. Further, during the first six months following the date of initial admission, the CBRF shall refund the entire entrance fee when the resident is discharged or when the resident meets the terms for notification to the CBRF of voluntary discharge as contained in the CBRF's admission agreement.

(3) **Changes.** The CBRF shall give the resident or the resident's legal representative a 30-day written notice of any change in services available or in charges for services that will be in effect for more than 30 days.

(4) **Conflicts.** DHS § 83.29(4) states that "No statement of the admission agreement may be in conflict with any part of this chapter, unless the department has granted a waiver or variance of a provision of this chapter."

3. What **cannot** be in a Nursing Home Admission Agreement. 42 CFR 483.15 and Section 49.498(7)(a) of the Wisconsin Statutes address precluded admissions practices of a nursing facility, including:

(a) A nursing facility may not require individuals applying to reside or residing in the facility to waive their rights to benefits under Medical Assistance or under Medicare;



(b) A nursing facility may not require oral or written assurance that individuals applying to reside or residing in the nursing facility are ineligible for or will not apply for Medical Assistance or Medicare;

(c) A nursing facility shall prominently display written information in the nursing facility and provide oral and written information to individuals applying to reside or residing in the nursing facility concerning how to apply for and use benefits under Medical Assistance and how to receive refunds for previous payments covered by these benefits;



(d) A nursing facility **may not** require a 3rd-party guarantee of payment to the nursing facility as a condition of admission or expedited admission to or continued stay in the nursing facility; and

(e) With respect to an individual who is entitled to Medical Assistance for nursing facility services, a nursing facility may not charge,

solicit, accept or receive, in addition to any amount otherwise required to be paid under the approved state Medicaid plan, a gift, money, donation or other consideration as a precondition of admitting or expediting the admission of an individual to the nursing facility or as a requirement for the individual's continued stay in the facility.

Despite these restrictions in both federal and state law, the provisions do not:

- Prevent a nursing facility from requiring an individual who has legal access to a resident's income or resources available to pay for care in the nursing facility, to sign a contract, *without incurring personal financial liability*, to provide payment from the resident's income or resources for care in the nursing facility;
- Prevent a nursing facility from charging a resident who is eligible for medical assistance for items or services that the resident has requested and received and that are not included in the approved state Medicaid plan; or
- Prohibit a nursing facility from soliciting, accepting or receiving a charitable, religious or philanthropic contribution from an organization or from a person who is unrelated to the resident or potential resident, but only to the extent that the contribution is not a condition of admission, expediting admission or continued stay in the nursing facility.



(f) **Clarification from the Centers for Medicare and Medicaid Services.**

On November 18, 2024, CMS issued new guidance related to the prohibition against admission agreements containing language requesting or requiring a third-party guarantee of payment. Within its guidance, CMS provides that *any language in admission agreements that seeks to hold an individual besides the resident personally liable for an outstanding balance owed to the nursing facility may be noncompliant*. Language may be noncompliant even if the word “guarantee” is not used. In its guidance, CMS provides several examples of noncompliant language:

- Language that holds both (1) the resident and (2) the representative or other individual jointly responsible for any sums due to the facility (however, language that holds the resident solely responsible is permitted);
- Language that holds the representative or other third-party individual personally liable for breach of an obligation in the admission agreement, such as (1) failing to apply for Medicaid in a timely and complete manner or (2) allowing someone other than a signatory

to the agreement to spend the resident's resources that would be used to pay the nursing facility;

- Language that does not specifically mention a third-party guarantee but implies the resident could be discharged if the representative does not voluntarily agree to personally pay to prevent the discharge;
- Language that holds the representative or other individual personally liable for any amounts not paid to the facility in a timely manner because the representative or other individual did not provide accurate financial information or notify the facility of changes in the resident's financial information.



CMS clarifies in its guidance that noncompliant language cannot be present in the primary documents used as admission agreements or in other documents signed at admission, nor can facilities use such language in agreements regarding a resident's continued stay. While requiring a third-party guarantee is not allowed, facilities may request or require a resident representative who has legal access to the resident's resources to sign a contract, without incurring personal liability, to provide facility payment from the resident's resources.

It is important to note that CMS clarifies that third-party payors, such as insurance companies, are not considered third-party guarantors.

Because of the inability of nursing homes to require third-party guarantees, facilities are encouraged to implement more robust pre-admission screening processes to identify residents who may face payor source challenges over time. As a result of this guidance, nursing facilities may need to utilize other legal actions, such as evictions and suits for unpaid rent, against residents or their estates to recover outstanding balances.

4. What is in an Admission Agreement but maybe **should not be**



(a) An Arbitration clause. Arbitration clauses are permitted in admission agreements. However, can anyone other than the resident agree to them?

(1) Guardians. Pursuant to Wis. Stat. § 54.25(2)(b)(1), a ward “retains right to initiate grievances, including under state and federal law regarding resident or patient rights.

(A) Holley v. Silverado Living Management, Inc. (2020) 53 Cal.App.5th 197. In this case, Elizabeth Holley became a patient at the Silverado Senior Living facility when she was 77 years old and suffering from dementia and other medical problems. Diane and James Holley became Elizabeth's temporary conservators. When admitting Elizabeth to Silverado, Diane and James signed a “Resident-Community Arbitration Agreement” on her behalf. Six days later, the probate court granted Diane and James's petition, as Elizabeth's temporary conservators, to place Elizabeth at Silverado and ordered them to assume the role of Elizabeth's conservators with the authority to place her in a locked facility.

A few months later, Elizabeth died after suffering a humeral fracture, an injury to her arm, a fractured hip, and numerous bruises. Diane and James sued Silverado for elder abuse, negligence, breach of contract, and wrongful death. Silverado moved to compel arbitration, which the trial court denied after finding that Diane and James had no authority to bind Elizabeth to an arbitration agreement. Silverado appealed, arguing “the agreement to arbitrate was a ‘health care decision’ to which a conservator had the authority to bind a conservatee.”

The Court of Appeal affirmed. The court explained that, as temporary conservators, Diane and James “lacked the power to bind Elizabeth to an agreement giving up substantial rights, such as ‘the right to use the courts for redress of grievances,’ without her consent or a prior adjudication of her lack of capacity.” Prior cases have held that the decision to execute an arbitration agreement upon admission to a senior living facility is a healthcare decision. However, the power of a **temporary** conservator to make medical decisions on behalf of a conservatee is limited. If a conservatee’s lack of capacity has not been adjudicated, then the conservatee must consent to medical treatment (including arbitration). Here, there was no evidence of Elizabeth’s consent, and a court first ruled that she lacked capacity six days after Diane and James executed the arbitration agreement on her behalf. Diane and James therefore lacked the power to bind Elizabeth to arbitration at the time they executed the agreement.”

(B) CL SNF, LLC v. No. S20G1292, 2021 WL 4268081 (Ga. Sept. 21, 2021). Here, a guardian contracted with a nursing home to care for her ward. When admitting the ward into the nursing home, the guardian signed an admission agreement that contained an arbitration clause, as well as a separate arbitration agreement, in which she agreed that any disputes with the nursing home would be resolved by an arbitrator. When a dispute later arose, however, the guardian sued the nursing home in court. When the nursing home sought to enforce the arbitration agreements, the county court held that the provision in the admission agreement was unenforceable because it violated federal law by giving the nursing home consideration beyond the Medicaid payments provided for the ward’s care. It further found that the separate arbitration agreement was unenforceable because it was not commercially reasonable and was unconscionable.



The Georgia Supreme Court concluded that Georgia’s guardianship code does grant a guardian authority to enter into a binding pre-dispute arbitration agreement where the exercise of such power is reasonably necessary to provide adequately for the ward’s support, care, health, and welfare. The Court held that such a power is one that is “reasonably necessary” to adequately provide for the ward, and the guardian had the power to execute a pre-dispute arbitration agreement on the ward’s behalf in connection with the provision of care. Otherwise, without possessing these related powers, guardians would either be unable to execute routine contracts such as telephone, banking, and utility contracts (most of which include arbitration agreements), or they would have to obtain approval from the probate court for each agreement, which would be impractical.

(2) Powers of Attorney.

(A) Wisconsin.



(i) Financial POA. Wis. Stat. § 244.43(4) authorizes an agent to “Initiate, participate in, submit to alternative dispute resolution, settle, oppose, or propose or accept a compromise with respect to a claim existing in favor of or against the principal or intervene in litigation relating to the claim.” Further, Wis. Stat.

§ 244.52(5) authorizes an agent to “submit to alternative dispute resolution, settle, and propose or accept a compromise.”

(ii) Health Care POA. Wis. Stat. § 155.20(2)(c)2.c. states that a health care agent may consent to the admission to a nursing home or community based residential facility for purposes other than recuperative care if document specifically authorizes, and if principal is not diagnosed as developmentally disabled or as having a mental illness.

(B) Outside Wisconsin. Bellhaven Senior Care LLC et. al v. Smith et al. (Mississippi Supreme Court 2022). Betty Smith brought a negligence and wrongful death lawsuit against Belhaven Senior Care, LLC, a nursing home facility in which her mother, Mary Hayes, had resided shortly before her death. Belhaven sought to compel arbitration, citing the arbitration provision in the nursing home admissions agreement Smith signed when admitting her mother. The trial judge denied arbitration, finding that Smith lacked the legal authority to bind her mother to the agreement. Belhaven appealed, arguing that under the Health-Care Decisions Act, Smith acted as a statutory healthcare surrogate. So, in signing the nursing home admission agreement, Smith had authority to agree to arbitration on her mother’s behalf.

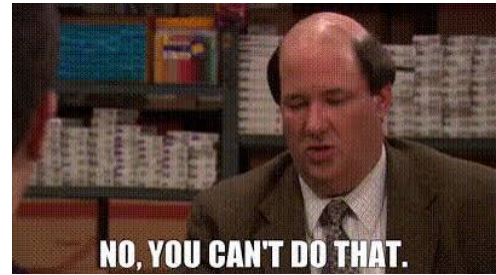
The Mississippi Supreme Court affirmed, finding that while Hayes did suffer from some form of dementia, Belhaven failed to prove the strict requirements of the surrogacy statute to rebut this presumption that she lacked capacity. Therefore, Smith could not compel her mother to the arbitration clause.

(b) Restrictions on Medicaid Planning. Many facilities include provisions in their admission agreement prohibiting residents from pursuing legal strategies to qualify for Medicaid.

(1) Sample provisions include:

(A) “_____ will not accept people for admission who have artificially qualified for Medicaid.”

(B) “Resident agrees not to deplete Resident’s assets by gifts or other transfers or purchases in a way that (i) is inconsistent with Resident’s financial practices during the 24 month period prior to residing at _____ or (ii) could, in the reasonable discretion of _____, jeopardize Resident’s ability to use Resident’s personal assets to pay for items or services provided to Resident by _____. It is the mutual understanding of _____ and Resident that Resident’s resources so stated are indicative of the funds available to pay for care and services provided throughout _____’s care continuum.”



(C) “I acknowledge that the house at the below address will be put on the market by x date. I also agree that the house will be sold no later than x date and I will keep in touch with the Executive Director as to the sale of the home, and the status. The home has no mortgage on it and all proceeds, less realtor fees will be applied to the care of resident. If for some reason the house is not sold and funds are not available to pay for his/her care, _____ reserves the right to issue a 30-day notice.”

(D) “Resident shall not transfer any property to any trust at any time, except that Resident may transfer property to a trust that is created and revocable by Resident and whose assets are available to satisfy all claims against Resident both during Resident’s life and after Resident’s death.”



(E) “Resident and Responsible Party agree not to transfer or otherwise divest or give away assets of the Resident, including any assets held jointly or in common with others, for less than fair market value to any third party. The Resident and Responsible Party agree to use these assets for payment of the Resident’s stay at _____ until the assets are exhausted and Medical Assistance has been obtained.”

(F) “Resident and the Responsible Party agree to turn over Resident’s monthly income less the personal needs allowance to Facility.”

(G) “Any transfer of Resident’s assets to establish or maintain eligibility for financial assistance, including but not limited to a transfer to any trust, another individual, or as a gift, is prohibited under this Agreement and will entitle Facility to damages, including liquidated damages, the cost differential between a private pay resident and a Medicaid resident and the costs of enforcing the provisions of this agreement, including attorney’s fees.”

(H) “Failure by the Responsible Party to appropriately use resident’s funds and assets for Resident’s care at facility may constitute abuse and/or financial exploitation. Inappropriate use of Resident’s funds and assets will be reported to the state and may result in criminal liability.”

(I) “Resident shall not add parties as joint owners or as co-signers to any accounts, execute any durable powers of attorney, or transfer property to any trustee without providing prior notice to Facility. Facility shall have the right to require any agent in custody of Resident’s funds to certify in writing that agent will preserve Resident’s financial ability to pay all of Resident’s responsibilities under this agreement.”

(2) Methodist Manor Health Center, Inc. v. Py, 2008 WI App 31, 746 NW 2d 824 (2008). The Wisconsin Court of Appeals held that a woman who served as her grandmother’s agent under a power of attorney is not responsible for her grandmother’s unpaid nursing home bill, even though she helped spend the money. The grandmother had told the nursing home that she would reserve money to pay for her care. The granddaughter signed an admission agreement with the facility that contained a clause that she would not deplete her assets “by gifts or other inappropriate transfers or purchases which would endanger [her] ability of continued self-support.”



However, the grandmother subsequently spent nearly all of her assets with the help of her granddaughter, power of attorney holder, and had no funds left to pay the nursing home. The nursing home sued both the grandmother and granddaughter. On appeal, the court found that the granddaughter had simply followed her grandmother’s instructions by giving her the money the grandmother had requested. The court also found no evidence that the granddaughter had taken money or wrongly diverted funds intended for her grandmother’s care. The nursing home had argued that it could hold the granddaughter liable under Methodist Manor of Waukesha Inc. v. Martin, 255 Wis. 2d 707 (Wis. Ct. App. 2002), which held that a nursing home could hold a resident’s son liable for an unpaid bill under the theory of conversion. The Wisconsin Court distinguished that because there was no evidence that the granddaughter did anything other than follow her grandmother’s instructions. The granddaughter’s primary obligation was her fiduciary duty to her grandmother under the power of attorney. Consequently, the granddaughter simply fulfilled this duty by following her grandmother’s instructions regarding her financial affairs.

The court held that when the grandmother executed the power of attorney document, an agency relationship was created with her granddaughter as the agent and herself as the principal. Losee v. Marine Bank, 2005 WI App 184, ¶ 16, 286 Wis.2d 438, 703 N.W.2d 751, states that “It is a well-established tenet of agency law that an attorney-in-fact has a fiduciary obligation to the principal.” The granddaughter’s conduct, unlike that alleged on the part of the son in Martin, comported with her fiduciary responsibilities as agent, first and foremost, to her grandmother, as her principal. Bockemuhl v. Jordan, 270 Wis. 14, 18, 70 N.W.2d 26 (1955), held that “Absolute fidelity and loyalty to the interests of his [or her] principal is the first duty and the highest obligation of an agent.”

(3) Otterbein Maineville LLC v. Carman, 2025 Ohio 1013 (Ohio Ct. App 2025). Joan Carman, an elderly woman with dementia, required nursing home care at Otterbein Maineville, LLC. Her son, Douglas Carman, arranged for her admission, indicating that Medicaid would cover her care costs. Douglas signed a “Consent to Treat & Admission Agreement” as Joan’s agent, but Joan did not sign the agreement herself. The agreement contained a provision stating, “Duty to Pay. You agree to pay all charges and fees that are billed to You by Otterbein when they become due. You agree to use Elder's income, assets, personal and real property, and resources, including, but not limited to, social security, pension or retirement funds, annuities, insurance, bank accounts, and mutual funds (collectively, “Resources”) to pay the charges when due, and agree to liquidate any Resources to pay such charges.”

It further stated, “You have asserted that the Representative has legal access to and control over the Resident's income, assets, personal, and real property, and resources, including, but not limited to, social security, pension or retirement funds, annuities, insurance, bank accounts, and mutual funds (collectively “Resources”), and You understand that Otterbein is entering into this Agreement in reliance on that assertion. You agree that all such Resources shall be considered the Resident’s Resources for purposes of this Agreement. You agree to take all steps necessary to prevent any of these Resources from transferring by operation of law while the Resident still has outstanding debts to Otterbein.



Unpaid bills accrued at the facility. Douglas eventually sold the house and received \$82,000. Instead of paying the \$72,000 outstanding bill at the facility, he transferred the funds into a pooled trust. The facility sued, alleging unjust enrichment against Joan and breach of contract against Douglas. The court granted summary judgment against Joan and Douglas, which was upheld on appeal.

5. What is **not** in an Admission Agreement but maybe **should be**

(a) The Facility’s Policy on Medicaid and Family Care.

(1) Does the facility accept Medicaid? If so, when? Immediately? If not, is there a private pay requirement? For how long? 12 months? 24 months?



(2) Is there a limit on how many beds can be filled by Medicaid residents? Are those beds in particular rooms, or can they be in any room? Is Medicaid accepted in all areas of the facility/at all levels of care?

(3) What happens if the resident’s assets are depleted before

the private pay requirement is up and/or there are no “Medicaid beds” available?

(b) The Duration of the Facility’s Ability to Care for Residents? As previously discussed, many residents are assured that they will be able to stay at a facility until they die. If the facility is making these assurances, should they be included in the agreement?

6. Discharges from Facilities. Discharging residents from long-term care facilities come with strict legal requirements.

(a) Key Questions to Remember.

(1) Did the facility put its notice in writing?

(A) Nursing Homes. Transfers and Discharges initiated by nursing homes are governed by DHS 132.53(3), which states that the facility shall provide a resident, the resident’s physician and, if known, an immediate family member or legal counsel, guardian, relative or other responsible person at least 30 days’ notice of transfer or discharge, and the reasons for the transfer or discharge, unless the continued presence of the resident endangers the health, safety or welfare of the resident or other residents.

(B) CBRFs.

Discharges or Transfers Initiated by CBRFs are governed by DHS 83.31(4):

(i) Before a CBRF involuntarily discharges a resident, the licensee shall give the resident or legal representative a 30-day written advance notice.



(ii) Every notice of involuntary discharge shall be in writing to the resident or the resident’s legal representative.

(2) Did the written notice contain the required information?

(A) Nursing Homes. Per DHS 132.53, the facility shall provide a resident, the resident’s physician and, if known, an immediate family member or legal counsel, guardian, relative or other responsible person at least 30 days’ notice of transfer or discharge, and the reasons for the transfer or discharge, unless the continued presence of the resident endangers the health, safety or welfare of the resident or other residents.

(B) CBRFs. Per DHS 83.31(4):

(i) The notice shall explain to the resident or legal representative the need for and possible alternatives to the discharge.

(ii) Every notice of involuntary discharge shall be in writing to the resident or resident's legal representative and shall include all of the following:



a. A statement setting forth the reason and justification for discharge.

b. A statement that the resident or the resident's legal representative may ask the Department to review the involuntary discharge by sending a written request within 10 days of receipt of the discharge statement to the Department's regional office with a copy to the CBRF. The notice shall state that the request must provide an explanation why the discharge should not take place.

c. The name, address and telephone number of the Department's regional office director.

d. The name, address and telephone number of the Regional Office of the Board on Aging and Long Term Care's Ombudsman program. For residents with developmental disability or mental illness, the notice shall include the name, address and telephone number of the protection and advocacy agency designated under § 51.62 (2) (a), Wis. Stats.

(3) Is the stated reason for discharge a legitimate reason?

(A) Nursing Homes. Homes: DHS 132.53(2) states that no resident may be discharged or transferred from a facility, except:

(i) Upon the request or with the informed consent of the resident or guardian;

(ii) For nonpayment of charges, following reasonable opportunity to pay any deficiency;

(iii) If the resident requires care other than that which the facility is licensed to provide;

(iv) If the resident requires care which the facility does not provide and is not required to provide under this chapter;



(v) For medical reasons as ordered by a physician;

(vi) In case of a medical emergency or disaster;

(vii) If the health, safety or welfare of the resident or other residents is endangered, as documented in the resident's clinical record;

(viii) If the resident does not need nursing home care;

(ix) If the short-term care period for which the resident was admitted has expired; or

(x) As otherwise permitted by law.

(B) CBRFs. DHS 83.31(4)(b) governs reasons for involuntary discharge. The CBRF may not involuntarily discharge a resident except for any of the following reasons:

(i) Nonpayment of charges, following reasonable opportunity to pay.

(ii) Care is required that is beyond the CBRF's license classification.

(iii) Care is required that is inconsistent with the CBRF's program statement and beyond that which the CBRF is required to provide under the terms of the admission agreement and this chapter.



(iv) Medical care is required that the CBRF cannot provide.

(v) There is imminent risk of serious harm to the health or safety of the resident, other residents or employees, as documented in the resident's record.

(vi) As provided under § 50.03 (5m), Wis. Stats. [the facility is operating with a revoked or suspended license or is closing].

(vii) As otherwise permitted by law.

(4) Has the facility taken the appropriate steps in addition to written notice?

(A) Nursing Homes.

(i) DHS 132.53(3)(b) requires a planning conference. Unless circumstances posing a danger to the health, safety or welfare of a resident require otherwise, at least 7 days before the planning conference, the resident, guardian, if any, any appropriate county agency, and others designated by the resident, including the resident's physician, shall be given a notice containing the time and place of the conference, a statement informing the resident that any persons of the resident's choice may attend the conference, and the procedure for submitting a complaint to the department.

(ii) Unless the resident is receiving respite care or unless precluded by circumstances posing a danger to the health, safety, or welfare of a resident, prior to any involuntary transfer or discharge, a planning conference shall be held at least 14 days before transfer or discharge with the resident, guardian, if any, any appropriate county agency, and others designated by the resident, including the resident's physician, to review the need for relocation, assess the effect of relocation on the resident, discuss alternative placements and develop a relocation plan, which includes at least the following activities:



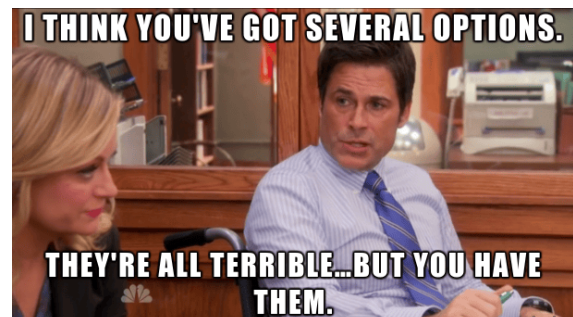
- a. Counseling regarding the impending transfer or discharge;
- b. The opportunity for the resident to make at least one visit to the potential alternative placement, if any, including a meeting with that facility's admissions staff, unless medically contraindicated or waived by the resident;
- c. Assistance in moving the resident and the resident's belongings and funds to the new facility or quarters; and
- d. Provisions for needed medications and treatments during relocation.

(iii) DHS 132.53(2)(b) governs alternate placement, and states except for transfers or discharges...for nonpayment or in a medical emergency, no resident may be involuntarily transferred or discharged unless an alternative placement is arranged for the resident. The resident shall be given reasonable advance notice of any planned transfer or discharge and an explanation of the need for and alternatives to the transfer or discharge except when there is a medical emergency. The facility, agency, program or person to which the resident is transferred shall have accepted the resident for transfer in advance of the transfer, except in a medical emergency.

(B) CBRFs. DHS 83.31(4)(a)(2) requires a CBRF to provide assistance in relocating the resident and shall ensure that a living arrangement suitable to meet the needs of the resident is available before discharging the resident. **NOTE:** No planning conference is required in a CBRF setting.

(5) If the facility did not follow the proper steps, what options does a resident have?

(A) If the resident wants to stay, they can follow the appeal process.



(i) Nursing Homes. The process for appealing an involuntary discharge from a nursing home is found in DHS 132.53(6)(b):

a. If a resident wishes to appeal a transfer or discharge decision, the resident shall send a letter to the nearest regional office of the Department's Bureau of Quality Assurance within 7 days after receiving a notice of transfer or discharge from the facility, with a copy to the facility administrator, asking for a review of the decision.

b. The resident's written appeal shall indicate why the transfer or discharge should not take place.

c. Within 5 days after receiving a copy of the resident's written appeal, the facility shall provide written justification to the Department's Bureau of Quality Assurance for the transfer or discharge of the resident from the facility.

d. If the resident files a written appeal within 7 days after receiving notice of transfer or of discharge from the facility, the resident may not be transferred or discharged from the facility until the Department's Bureau of Quality Assurance has completed its review of the decision and notified both the resident and the facility of its decision.

e. The Department's Bureau of Quality Assurance shall complete its review of the facility's decision and notify both the resident and the facility in writing of its decision within 14 days after receiving written justification for the transfer or discharge of the resident from the facility.

f. A resident or a facility may appeal the decision of the Department's Bureau of Quality Assurance in writing to the Department of Administration's Division of Hearings and Appeals within 5 days after receipt of the decision.

(ii) CBRFs: The process for appealing an involuntary discharge from a CBRF is found in DHS 83.31(4)(d):



a. A resident may request Department review of an involuntary discharge within 10 days of receipt of such notice. If a timely request is sent to the Department, the CBRF may not proceed with an involuntary discharge until the Department has completed its review and notified the resident or the resident's legal representative and the CBRF of the Department's decision.

b. Within 7 days after receiving the copy of the letter requesting the review, the CBRF may provide to the Department's Regional Office, additional information justifying the discharge.

c. The Department shall complete its review within 10 days after the CBRF submits additional information, if any, and will notify in writing the resident or the resident's legal representative and the CBRF of the Department's decision.

(B) If NO, the resident DOES NOT want to stay at the facility, but *wants to buy more time*, they may still follow appeal process (see above).

(C) If NO, the resident DOES NOT want to stay at facility at all, they may still consider filing a grievance. DHS 83.33(1)(a) states that a resident or any individual on behalf of the resident may file a grievance with the CBRF, the Department, the resident's case manager, if any, the Board on Aging and Long Term Care, Disability Rights Wisconsin, Inc., or any other organization providing advocacy assistance. The resident and the resident's legal representative shall have the right to advocate throughout the grievance procedure. The written grievance procedure shall include the name, address and phone number of organizations providing advocacy for the client groups served, and the name, address and phone number of the department's regional office that licenses the CBRF.

