S. HRG. 110–173

THE NURSING HOME REFORM ACT TURNS TWENTY: WHAT HAS BEEN ACCOMPLISHED, AND WHAT CHALLENGES REMAIN?

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

WASHINGTON, DC

MAY 2, 2007

Serial No. 110–6

Printed for the use of the Special Committee on Aging

THE NURSING HOME REFORM ACT TURNS TWENTY: WHAT HAS BEEN ACCOMPLISHED, AND WHAT CHALLENGES REMAIN?

S. HRG. 110–173

THE NURSING HOME REFORM ACT TURNS TWENTY: WHAT HAS BEEN ACCOMPLISHED, AND WHAT CHALLENGES REMAIN?

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

WASHINGTON, DC

MAY 2, 2007

Serial No. 110–6

Printed for the use of the Special Committee on Aging

Available via the World Wide Web: http://www.gpoaccess.gov/congress/index.html

U.S. GOVERNMENT PRINTING OFFICE

37–151 PDF WASHINGTON : 2007

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

SPECIAL COMMITTEE ON AGING

HERB KOHL, Wisconsin, *Chairman*

RON WYDEN, Oregon	GORDON H. SMITH, Oregon
BLANCHE L. LINCOLN, Arkansas	RICHARD SHELBY, Alabama
EVAN BAYH, Indiana	SUSAN COLLINS, Maine
THOMAS R. CARPER, Delaware	MEL MARTINEZ, Florida
BILL NELSON, Florida	LARRY E. CRAIG, Idaho
HILLARY RODHAM CLINTON, New York	ELIZABETH DOLE, North Carolina
KEN SALAZAR, Colorado	NORM COLEMAN, Minnesota
ROBERT P. CASEY, Jr., Pennsylvania	DAVID VITTER, Louisiana
CLAIRE McCASKILL, Missouri	BOB CORKER, Tennessee
SHELDON WHITEHOUSE, Rhode Island	ARLEN SPECTER, Pennsylvania

JULIE COHEN, *Staff Director*
CATHERINE FINLEY, *Ranking Member Staff Director*

CONTENTS

THE NURSING HOME REFORM ACT TURNS TWENTY: WHAT HAS BEEN ACCOMPLISHED, AND WHAT CHALLENGES REMAIN?

WEDNESDAY, MAY 2, 2007

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The Committee met, pursuant to notice, at 10:28 a.m., in room 628, Dirksen Senate Office Building, Hon. Herb Kohl (chairman of the committee) presiding.

Present: Senators Kohl and McCaskill.

OPENING STATEMENT OF SENATOR HERB KOHL, CHAIRMAN

The CHAIRMAN. Hello. At this time, we will call this hearing to order. We welcome all of our guests and witnesses who are present.

Back in January, as Chairman of the Committee, I promised that we would take a close look at nursing homes to see if our seniors are getting the safest, highest-quality care. Today, we are going to do exactly that.

We know that the vast majority of nursing home providers care deeply about their residents, and are doing their very best to provide the best possible care. But as we will hear today, many problems still exist in some of our Nation's nursing homes.

The Nursing Home Reform Act became law 20 years ago. Better known as OBRA 1987, this law set Federal standards for the quality of services for staffing and for inspection and oversight of long-term care facilities.

Without question, it has improved nursing home care. For example, OBRA 1987 led to a sharp drop in unnecessary physical and chemical restraints of residents. Other accomplishments and events are on the posters on this podium.

We will hear today from GAO that, in 2006, nearly one in five nursing homes nationwide were cited for poor care that caused actual harm to residents. Among a group of facilities studied in 1998 and 1999 that provided poor care, the agency found that nearly half have made no progress between that time and now. Now, this is unacceptable, and it raises questions about how and why our enforcement system is not getting the job done.

From CMS, we will hear about the challenges facing State inspection agencies in overseeing nursing homes. Surveys do the tough work of visiting facilities, documenting the conditions and deficiencies they find, and recommending sanctions. But it is trou-

bling that fines and sanctions are often not levied, even when inspectors find violations that leave residents suffering.

For facilities that continually slip in and out of compliance, regulators need to take much swifter action. Bad apples give the nursing home industry a black eye, and they should not be in this business.

This Committee has a long history of closely scrutinizing the quality of nursing home care, and we intend to reaffirm that commitment. We need to regularly monitor the nursing home industry and the performance of Federal and State regulators to make sure quality standards are met.

As a first step, we will follow this hearing with a written request to CMS to brief us every 2 months on progress made to implement the recommendations and GAO's testimony that come out of this hearing. We will continue to press the Administration to tighten up the enforcement system and make sanctions stick.

We will work with advocates, the industry and regulators on proposals to tighten the enforcement process, so that the bad actors no longer escape sanctions.

We will also be requesting ideas for improving public information about the quality of nursing homes. When consumers look at CMS's Nursing Home Compare Web site, they should be better able to tell immediately which facilities are providing good care and which are providing substandard care.

We also want to make sure that the nursing home workforce is the best it can be by establishing a nationwide system of background checks for workers in long-term care facilities.

Today, we will hear about groundbreaking work being done in the State of Michigan. They have successfully organized a streamlined, cost-effective system of background checks for people who apply for jobs in long-term care facilities.

Michigan's program is being conducted as part of a pilot program that was started in 2003. This program is producing impressive results in other States as well, including my own State of Wisconsin, and I believe it is time to expand it nationwide.

The vast majority of long-term care workers do an excellent job at taking care of our family members. But individuals who have a record of criminal abuse obviously should not care for the most vulnerable in our society. To that end, I plan to introduce legislation that is modeled on Michigan's background check program.

We look forward to joining with all of our colleagues on this Committee and in the Congress to ensure that all nursing home residents are safe and receive the highest quality of care. Clearly, our Nation's families deserve nothing else.

At this time, I would like to welcome our first panel to come forward.

Our first witness will be Kathryn Allen, who is director of Health Care for the U.S. Government Accountability Office. Ms. Allen has extensive expertise in Medicaid, children's health issues and long-term care issues, including nursing homes. Ms. Allen has had a long and distinguished career at GAO, also directing studies on private health insurance issues, medical malpractice and access to care.

Also on this panel we have Dr. James Randolph Farris of the Centers for Medicare and Medicaid Services, CMS. Dr. Farris has served as the regional administrator of the Dallas office since 1998. In this capacity, Dr. Farris has responsibility for Medicare, Medicaid, the Clinical Laboratory Improvement Act, and State Children's Health Insurance Programs in the States of Texas, Oklahoma, New Mexico, Arkansas and Louisiana. He also serves as the lead CMS Regional Administrator for rural health issues and for the survey and certification program.

We thank you very much for being with us.

At this time, Ms. Allen, we would like to hear your testimony.

STATEMENT OF KATHRYN ALLEN, DIRECTOR OF HEALTH CARE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE, WASHINGTON, DC

Ms. ALLEN. Thank you, Mr. Chairman. I am pleased to be here today as the Committee acknowledges the 20th anniversary of the passage of OBRA 1987, which, as you have already mentioned, contained very important nursing home reform provisions.

The Nation's 1.5 million nursing home residents are a very vulnerable population of elderly and disabled individuals for whom remaining at home is no longer feasible. This population is also expected to increase dramatically in future years, along with the cost of their care, with the aging of the baby-boomer population.

The public investment is large. Combined Medicare and Medicaid payments for nursing home services were almost $73 billion in 2005, including a Federal share of about $49 billion.

In 1986, the Institute of Medicine reported, among other things, the quality of care in many nursing homes was not satisfactory. In 1987, GAO issued a report that recommended, consistent with that report, that Congress pass legislation to strengthen enforcement of Federal nursing home requirements.

Subsequent to these reports, Congress enacted the nursing home provisions of OBRA 1987, which changed the focus of quality standards from inputs in a home's capability to provide care to its actual delivery of care and the outcomes of that care.

Since this Committee subsequently asked GAO to investigate the quality of care in California nursing homes in 1997, we have reported to and testified before the Congress many times on these issues, identifying issues and problems in Federal and State activities that have been designed to detect and correct quality problems. We have made numerous recommendations to improve enforcement and oversight.

CMS has taken many actions in response to our recommendations, and has also undertaken its own initiatives to address these and other issues. As a result of OBRA and these other more recent efforts, much has transpired over the last 20 years in terms of assessing, overseeing and improving the quality of nursing home care.

My remarks today will focus on progress made and some of the challenges that remain in three specific areas: evaluating the quality of nursing home care and the enforcement and oversight functions intended to ensure high-quality care. My statement will be based on our prior work.

First, OBRA 1987's reforms and subsequent efforts by CMS and the nursing home industry to improve the quality of care have indeed focused on resident outcomes, as was intended.

However, as you have already pointed out, a small but significant share of nursing homes nationwide continue to experience quality-of-care problems. In last fiscal year 2006, almost one in five nursing homes nationwide was cited for serious deficiencies—those that caused actual harm or placed residents in immediate jeopardy.

Now, while this rate has varied over the last 7 years, we have regularly found persistently wide variation across the States in terms of the rate at which they cite serious deficiencies, which indicates inconsistency in how they assess quality of care. We have also found understatement in the severity of reported deficiencies in States where we have reviewed this in more depth.

My second point: CMS has indeed strengthened its enforcement capabilities since OBRA 1987 to better ensure that nursing homes achieve and maintain high-quality care. For example, the agency has implemented additional sanctions authorized in the legislation, such as civil monetary penalties. It has established an immediate sanctions policy for nursing homes found to repeatedly harm residents, and it has developed a new enforcement management system. However, several important initiatives require refinement.

We recently reported that the deterrent effect of CMPs, civil monetary penalties, was diluted for a sample of homes that we reviewed with a history of serious deficiencies, because CMS often imposed penalties at the lower end of the allowable range. Significant time, sometimes years, could pass between the citation of deficiencies on a survey and a home's payment because they are allowed to appeal, and the penalty is not required to be paid while it is under appeal.

We also found that CMS's immediate sanctions policy is complex and appears to induce only temporary compliance for homes with a history of noncompliance. Moreover, CMS's new enforcement data system are not well-integrated, and the national reporting capabilities are incomplete, which hinders the agency's ability to track and monitor enforcement.

Third, CMS has increased its oversight of nursing home quality and State surveys since the passage of OBRA 1987. But certain initiatives continue to compete for staff and financial resources.

In recent years, CMS has focused its resources on prompt investigation of complaints and allegations of abuse. It has conducted more frequent and many more Federal comparative surveys. It has strengthened its fire safety standards and has upgraded its data systems.

But CMS's intensified oversight efforts, coupled with an increase in the number of Medicare-Medicaid providers, has produced greater demands on its resources, which has led to delays in certain very important activities. For example, the implementation of new survey methodology has been in process for 8 years, and resource constraints threaten the planned expansion of this methodology beyond the initial demonstration sites.

In conclusion, Mr. Chairman, significant attention from this Committee, the Congress, the Institute of Medicine and others served as a very important catalyst to focus national attention on

nursing home quality issues that culminated in the nursing home reform provisions of OBRA 1987.

Most would agree that many significant reforms and measures have been initiated and implemented since that time to improve the quality of nursing home care. But the task is not complete. It is imperative to continue to focus national attention on and to ensure public accountability for nursing homes to provide high-quality care for all residents.

With such ongoing efforts, the momentum of earlier initiatives can be sustained and perhaps even enhanced, so that quality of care for all nursing home residents can be secured, as surely was intended by the Congress when it passed this legislation.

Mr. Chairman, this concludes my prepared remarks.

[The prepared statement of Ms. Allen follows:]

United States Government Accountability Office

GAO

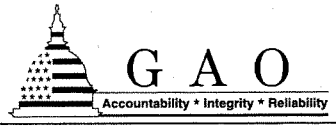
Testimony
Before the Special Committee on Aging, U.S. Senate

For Release on Delivery
Expected at 10:30 a.m. EDT
Wednesday, May 2, 2007

NURSING HOME REFORM

Continued Attention Is Needed to Improve Quality of Care in Small but Significant Share of Homes

Statement of Kathryn G. Allen
Director, Health Care



May 2, 2007

GAO
Accountability · Integrity · Reliability
Highlights

Highlights of GAO-07-794T, a testimony before the Special Committee on Aging, U.S. Senate

NURSING HOME REFORM

Continued Attention Is Needed to Improve Quality of Care in Small but Significant Share of Homes

Why GAO Did This Study

With the Omnibus Budget Reconciliation Act of 1987 (OBRA '87), Congress responded to growing concerns about the quality of care that nursing home residents received by requiring reforms in the federal certification and oversight of nursing homes. These reforms included revising care requirements that homes must meet to participate in the Medicare or Medicaid programs, modifying the survey process for certifying a home's compliance with federal standards, and introducing additional sanctions and decertification procedures for noncompliant homes.

GAO's testimony addresses its work in evaluating the quality of nursing home care and the enforcement and oversight functions intended to ensure high-quality care, the progress made in each of these areas since the passage of OBRA '87, and the challenges that remain.

GAO's testimony is based on its prior work; analysis of data from the Centers for Medicare & Medicaid Services' (CMS) On-Line Survey, Certification, and Reporting system (OSCAR), which compiles the results of state nursing home surveys; and evaluation of federal comparative surveys for selected states (2005-2007). Federal comparative surveys are conducted at nursing homes recently surveyed by each state to assess the adequacy of the state's surveys.

www.gao.gov/cgi-bin/getrpt?GAO-07-794T.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Kathryn G. Allen at (202) 512-7118 or allenk@gao.gov.

What GAO Found

The reforms of OBRA '87 and subsequent efforts by CMS and the nursing home industry to improve the quality of nursing home care have focused on resident outcomes, yet a small but significant share of nursing homes nationwide continue to experience quality-of-care problems. In fiscal year 2006, almost one in five nursing homes was cited for serious deficiencies, those that caused actual harm or placed residents in immediate jeopardy. While this rate has fluctuated over the last 7 years, GAO has found persistent variation in the proportion of homes with serious deficiencies across states. In addition, although the understatement of serious deficiencies—that is, when federal surveyors identified deficiencies that were missed by state surveyors—has declined since 2004 in states GAO reviewed, it has continued at varying levels.

CMS has strengthened its enforcement capabilities since OBRA '87 in order to better ensure that nursing homes achieve and maintain high-quality care, but several key initiatives require refinement. CMS has implemented additional sanctions authorized in the legislation, established an immediate sanctions policy for homes found to repeatedly harm residents, and developed a new enforcement management data system. However, the immediate sanctions policy is complex and appears to have induced only temporary compliance in some homes with a history of repeated noncompliance. Furthermore, CMS's new data system's components are not integrated and national reporting capabilities are incomplete, which hamper CMS's ability to track and monitor enforcement.

CMS oversight of nursing home quality has increased significantly, but CMS initiatives continue to compete for staff and financial resources. Attention to oversight has led to greater demand on limited resources, and to queues and delays in certain key initiatives. For example, a new survey methodology has been in development for over 8 years and resource constraints threaten the planned expansion of this methodology beyond the initial demonstration states.

Significant attention from the Special Committee on Aging, the Institute of Medicine, and others served as a catalyst to focus national attention on nursing home quality issues, culminating in the nursing home reform provisions of OBRA '87. In response to many GAO recommendations and at its own initiative, CMS has taken many important steps; however, the task of ensuring high-quality nursing home care for all residents is not complete. In order to guarantee that all nursing home residents receive high-quality care, it is important to maintain the momentum begun by the reforms of OBRA '87 and continue to focus national attention on those homes that cause actual harm to vulnerable residents.

Mr. Chairman and Members of the Committee:

I am pleased to be here today as you acknowledge the 20th anniversary of the passage of the Omnibus Budget Reconciliation Act of 1987 (OBRA '87), which contained nursing home reform provisions. In March 1986, the National Academy of Sciences' Institute of Medicine (IOM) released a report concluding that quality of care and quality of life in many nursing homes were not satisfactory, despite the existence of government regulation, and that more effective government regulation could substantially improve nursing home quality.[1] In July 1987, we issued a report recommending that Congress pass legislation that would strengthen enforcement of federal nursing home requirements, consistent with the IOM's recommendations.[2] Largely in response to these reports, Congress passed the nursing home reform provisions of OBRA '87, which was significant in that it changed the focus of quality standards from a home's capability to provide care to its actual delivery of care and resident outcomes. OBRA '87 directed the Health Care Financing Administration, now known as the Centers for Medicare & Medicaid Services (CMS), to reform its certification and oversight of nursing homes for Medicare and Medicaid, which includes surveys to ensure the quality of resident care, complaint investigations, and remedies and penalties for nursing homes not in compliance with federal standards.[3]

The nation's 1.5 million nursing home residents are a highly vulnerable population of elderly and disabled individuals for whom remaining at home is no longer feasible. With the aging of the baby boom generation, the number of individuals needing nursing home care and the associated costs are expeeted to increase dramatically. Combined Medicare and Medicaid payments for nursing home services were about $72.7 billion in 2005, including a federal share of about $49 billion. The federal

[1]See Institute of Medicine, National Academy of Sciences, *Improving the Quality of Care in Nursing Homes* (Washington, D.C.: March 1986).

[2]GAO, *Medicare and Medicaid: Stronger Enforcement of Nursing Home Requirements Needed*, GAO/HRD-87-113 (Washington, D.C.: July 22, 1987).

[3]Prior to July 2001, CMS was known as the Health Care Financing Administration. Throughout this testimony, we refer to the agency as CMS, even when describing initiatives taken prior to its name change. Medicare is the federal health care program for elderly and disabled people. Medicare may cover up to 100 days of skilled nursing home care following a hospital stay. Medicaid is the joint federal-state health care financing program for certain categories of low-income individuals. Medicaid also pays for long-term care services, including nursing home care.

government plays a key role in ensuring that nursing home residents receive appropriate care by setting quality-of-care, quality-of-life, and life safety requirements that nursing homes must meet to participate in the Medicare and Medicaid programs and by contracting with states to routinely inspect homes and conduct complaint investigations.[4] To encourage compliance with these requirements, Congress has authorized certain enforcement actions.

Since this Committee requested us to investigate California nursing homes in 1997, we have reported to Congress and testified numerous times on the quality of resident care, identified significant weaknesses in federal and state activities designed to detect and correct quality problems in nursing homes, and made many recommendations to improve the survey process and federal oversight of nursing home quality.[5] In response to our recommendations as well as needed improvements CMS identified in its own self-assessment in 1998, CMS announced a set of initiatives intended to address many of these weaknesses. Over time, CMS has refined and expanded these initiatives in order to continue to improve nursing home quality.

My remarks today will focus on GAO's work in evaluating the quality of nursing home care and the enforcement and oversight functions intended to ensure high-quality care.[6] I will address the progress made in these three areas since OBRA '87, as well as the challenges that remain. This statement is based primarily on prior GAO work. In addition, we interviewed CMS officials; analyzed data from CMS's On-Line Survey, Certification, and Reporting system (OSCAR), which compiles the results of state nursing home surveys; and evaluated the results of federal comparative surveys for selected states for the period January 2005 through March 2007. Federal comparative surveys are conducted at nursing homes recently surveyed by each state to assess the adequacy of the state's surveys. We considered these data sufficiently reliable for our purposes. We discussed the highlights of this statement including our new

[4]In this report, we use the term states to include the 50 states and the District of Columbia.

[5]Related GAO products are included at the end of this statement. See appendix I for recommendations GAO has made, related CMS initiatives, and the implementation status of these initiatives.

[6]OBRA '87 included other requirements pertaining to nursing homes, such as staffing, services, and specific rights of residents, including privacy, restricted use of physical or chemical restraints, and voicing of grievances, but GAO has not examined these issues.

analyses with CMS officials, and they provided us additional information, which we incorporated as appropriate. We conducted our work from March through April 2007 in accordance with generally accepted government auditing standards.

In summary, despite the reforms of OBRA '87 and subsequent efforts by CMS and the nursing home industry to improve the quality of nursing home care, a small but significant share of nursing homes nationwide continues to experience quality-of-care problems. In 2006, one in five nursing homes nationwide was cited for serious deficiencies—those deficiencies that cause actual harm or place residents in immediate jeopardy. While this rate has fluctuated over the last 7 years, we have regularly found (1) significant variation across states in their citation of serious deficiencies, indicating inconsistencies in states' assessments of quality of care and (2) understatement of these deficiencies—when deficiencies are found on federal comparative surveys but not cited on corresponding state surveys. Among the five large states we reviewed—California, Florida, New York, Ohio, and Texas—understatement of serious deficiencies has declined from 18 percent prior to December 2004 to 11 percent for the most recent time period ending in March 2007, but understatement has continued at varying levels.

Since the passage of OBRA '87, CMS has strengthened its enforcement capabilities—for example, by implementing sanctions authorized in the legislation, establishing an immediate sanctions policy for nursing homes found to repeatedly harm residents, and developing a new enforcement management data system—but several key initiatives require refinement. The immediate sanctions policy is complex and appears to have induced only temporary compliance in certain nursing homes with histories of repeated noncompliance. In addition, the term "immediate sanctions" policy is misleading because it requires only that homes be notified immediately of CMS's intent to implement sanctions, not that sanctions be implemented immediately. Furthermore, when a sanction, such as a denial of payment for new admissions (DPNA), is implemented, there is a lag time between when the deficiency citation occurs and the effective date of the sanction. Finally, although CMS has developed a new data system, the system's components are not integrated and the national reporting capabilities are incomplete, hampering the agency's ability to track and monitor enforcement.

CMS oversight of nursing home quality and state surveys has increased since OBRA '87, but certain key initiatives continue to compete for resources. To increase its oversight of quality of care in nursing homes,

CMS has focused its resources and attention in areas such as prompt investigation of complaints and allegations of abuse, more frequent federal comparative surveys, stronger fire safety standards, and upgrades to data systems. However, this increased emphasis on nursing home oversight coupled with growth in the number of Medicare and Medicaid providers has caused greater demand on limited resources, which, in turn, has led to queues and delays in certain key initiatives. For example, the implementation of a new survey methodology, the Quality Indicator Survey (QIS), has been in development for over 8 years and resource constraints threaten the planned expansion of this methodology beyond the initial five demonstration states.

Significant attention from the Special Committee on Aging, the Institute of Medicine, and others served as a catalyst to focus national attention on nursing home quality issues, culminating in the nursing home reform provisions of OBRA '87. Since then, in response to many GAO recommendations and at its own initiative, CMS has taken many important steps to respond in a timelier, more rigorous, more consistent manner to identified problems. Nevertheless, the task of ensuring high-quality nursing home care is still not complete. To guarantee that all nursing home residents receive high-quality care, it is important to maintain the momentum begun by the reforms of OBRA '87 and continue to focus national attention on those homes that cause actual harm to vulnerable residents.

Background

Titles XVIII and XIX of the Social Security Act establish minimum requirements that all nursing homes must meet to participate in the Medicare and Medicaid programs, respectively. With the passage of OBRA '87, Congress responded to growing concerns about the quality of care that nursing home residents received by requiring major reforms in the federal regulation of nursing homes. Among other things, these reforms revised care requirements that facilities must meet to participate in the Medicare or Medicaid programs, modified the survey process for certifying a home's compliance with federal standards, and introduced additional sanctions and decertification procedures for homes that fail to meet federal standards. Following OBRA '87, CMS published a series of regulations and transmittals to implement the changes. Key implementation actions have included the following: In October 1990, CMS implemented new survey standards; in July 1995, it established enforcement actions for nursing homes found to be out of compliance; and it enhanced oversight through more rigorous federal monitoring surveys beginning in October 1998 and annual state performance reviews in fiscal year 2001. CMS has continued

to revise and refine many of these actions since their initial implementation.

Survey Process

Every nursing home receiving Medicare or Medicaid payment must undergo a standard survey not less than once every 15 months, and the statewide average interval for these surveys must not exceed 12 months.[7] During a standard survey, separate teams of surveyors conduct a comprehensive assessment of federal quality-of-care and life safety requirements. In contrast, complaint investigations, also conducted by surveyors, generally focus on a specific allegation regarding resident care or safety.[8]

The quality-of-care component of a survey focuses on determining whether (1) the care and services provided meet the assessed needs of the residents and (2) the home is providing adequate quality care, including preventing avoidable pressure sores, weight loss, and accidents. Nursing homes that participate in Medicare and Medicaid are required to periodically assess residents' care needs in 17 areas, such as mood and behavior, physical functioning, and skin conditions, in order to develop an appropriate plan of care. Such resident assessment data are known as the minimum data set (MDS). To assess the care provided by a nursing home, surveyors select a sample of residents and (1) review data derived from the residents' MDS assessments and medical records; (2) interview nursing home staff, residents, and family members; and (3) observe care provided to residents during the course of the survey. CMS establishes specific investigative protocols for state survey teams—generally consisting of registered nurses, social workers, dieticians, and other specialists—to use in conducting surveys. These procedural instructions are intended to make the on-site surveys thorough and consistent across states.

[7]CMS generally interprets these requirements to permit a statewide average interval of 12.9 months and a maximum interval of 15.9 months for each home. In addition to nursing homes, CMS and state survey agencies are responsible for oversight of other Medicare and Medicaid providers such as home health agencies, intermediate care facilities for the mentally retarded, accredited and nonaccredited hospitals, end-stage renal dialysis facilities, ambulatory surgical centers, rural health clinics, outpatient physical therapy centers, hospices, portable x-ray suppliers, comprehensive outpatient rehabilitation facilities, and Community Mental Health Centers.

[8]CMS contracts with state survey agencies to conduct surveys and complaint investigations.

The life safety component of a survey focuses on a home's compliance with federal fire safety requirements for health care facilities.[9] The fire safety requirements cover 18 categories, ranging from building construction to furnishings. Most states use fire safety specialists within the same department as the state survey agency to conduct fire safety inspections, but some states contract with their state fire marshal's office.

Complaint investigations provide an opportunity for state surveyors to intervene promptly if problems arise between standard surveys. Complaints may be filed against a home by a resident, the resident's family, or a nursing home employee either verbally, via a complaint hotline, or in writing. Surveyors generally follow state procedures when investigating complaints but must comply with certain federal guidelines and time frames. In cases involving resident abuse, such as pushing, slapping, beating, or otherwise assaulting a resident by individuals to whom their care has been entrusted, state survey agencies may notify state or local law enforcement agencies that can initiate criminal investigations. States must maintain a registry of qualified nurse aides, the primary caregivers in nursing homes, that includes any findings that an aide has been responsible for abuse, neglect, or theft of a resident's property. The inclusion of such a finding constitutes a ban on nursing home employment.

Effective July 1995, CMS established a classification system for deficiencies identified during either standard surveys or complaint investigations. Deficiencies are classified in 1 of 12 categories according to their scope (i.e., the number of residents potentially or actually affected) and their severity. An A-level deficiency is the least serious and is isolated in scope, while an L-level deficiency is the most serious and is considered to be widespread in the nursing home (see table 1). States are required to enter information about surveys and complaint investigations, including the scope and severity of deficiencies identified, in CMS's OSCAR database.

[9]CMS requires nursing homes to meet applicable provisions of the fire safety standards developed by the National Fire Protection Association (NFPA), of which CMS is a member. NFPA is a nonprofit membership organization that develops and advocates scientifically based consensus standards on fire, building, and electrical safety.

Table 1: Scope and Severity of Deficiencies Identified during Nursing Home Surveys

	Scope		
Severity	**Isolated**	**Pattern**	**Widespread**
Immediate jeopardy[a]	J	K	L
Actual harm	G	H	I
Potential for more than minimal harm	D	E	F
Potential for minimal harm[b]	A	B	C

Source: CMS.

[a]Actual or potential for death/serious injury.

[b]Nursing home is considered to be in "substantial compliance."

Enforcement

In an effort to better ensure that nursing homes achieve and maintain compliance with the new survey standards, OBRA '87 expanded the range of enforcement sanctions. Prior to OBRA '87, the only sanctions available were terminations from Medicare or Medicaid or, under certain circumstances, DPNAs. OBRA '87 added several new alternative sanctions, such as civil money penalties (CMP) and requiring training for staff providing care to residents, and expanded the types of deficiencies that could result in DPNAs. To implement OBRA '87, CMS published enforcement regulations, effective July 1995. According to these regulations, the scope and severity of a deficiency determine the applicable sanctions. CMS imposes sanctions on homes with Medicare or dual Medicare and Medicaid certification on the basis of state referrals.[10] CMS normally accepts a state's recommendation for sanctions but can modify it.

Effective January 2000, CMS required states to refer for immediate sanction homes found to have harmed one or a small number of residents or to have a pattern of harming or exposing residents to actual harm or potential death or serious injury (G-level or higher deficiencies on the agency's scope and severity grid) on successive surveys. This is known as the double G immediate sanctions policy. Additionally, in January 1999,

[10]Ensuring that documented deficiencies are corrected is a shared federal-state responsibility. States are responsible for enforcing standards in homes with Medicaid-only certification—about 14 percent of homes. They may use the federal sanctions or rely on their own state licensure authority and nursing home sanctions.

CMS launched the Special Focus Facility program. This initiative was intended to increase the oversight of homes with a history of providing poor care. When CMS established this program, it instructed each state to select two homes for enhanced monitoring. For these homes, states are to conduct surveys at 6-month intervals rather than annually. In December 2004, CMS expanded this program to require immediate sanctions for those homes that fail to significantly improve their performance from one survey to the next and termination for homes with no significant improvement after three surveys over an 18-month period.[11]

Unlike other sanctions, CMPs do not require a notification period before they go into effect. However, if a nursing home appeals the deficiency, by statute, payment of the CMP—whether received directly from the home or withheld from the home's Medicare and Medicaid payments—is deferred until the appeal is resolved.[12] In contrast to CMPs, other sanctions, including DPNAs, cannot go into effect until homes have been provided a notice period of at least 15 days, according to CMS regulations; the notice period is shortened to 2 days in the case of immediate jeopardy. Although nursing homes can be terminated involuntarily from participation in Medicare and Medicaid, which can result in a home's closure, termination is used infrequently.[13]

Oversight

CMS is responsible for overseeing each state survey agency's performance in ensuring quality of care in nursing homes participating in Medicare or Medicaid. Its primary oversight tools are (1) statutorily required federal monitoring surveys and (2) annual state performance reviews. Pursuant to OBRA '87, CMS is required to conduct annual monitoring surveys in at least 5 percent of the state-surveyed Medicare and Medicaid nursing homes in each state, with a minimum of five facilities in each state. These federal monitoring surveys can be either comparative or observational. A

[11]As of December 2004, Alaska is not required to select Special Focus Facilities, because there were fewer than 21 nursing homes in the state at that time.

[12]If efforts to collect the CMP directly from the home fail, Medicare and Medicaid payments are withheld.

[13]Homes also can choose to close voluntarily, but we do not consider voluntary closure to be a sanction. When a home is terminated, it loses any income from Medicare and Medicaid, which accounted for about 40 percent of nursing home payments in 2004. Residents who receive support through Medicare or Medicaid must be moved to other facilities. However, a terminated home generally can apply for reinstatement if it corrects its deficiencies.

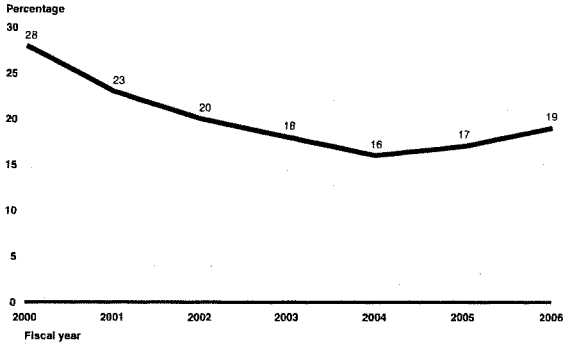
comparative survey involves a federal survey team conducting a complete, independent survey of a home within 2 months of the completion of a state's survey in order to compare and contrast the findings. In an observational survey, one or more federal surveyors accompany a state survey team to a nursing home to observe the team's performance. State performance reviews measure state survey agency compliance with seven standards: timeliness of the survey, documentation of survey results, quality of state agency investigations and decision making, timeliness of enforcement actions, budget analysis, timeliness and quality of complaint investigations, and timeliness and accuracy of data entry. These reviews replaced state self-reporting of their compliance with federal requirements.

Quality of Care Remains a Problem for a Small but Significant Proportion of Nursing Homes Nationwide

A small but significant proportion of nursing homes nationwide continue to experience quality-of-care problems—as evidenced by the almost 1 in 5 nursing homes nationwide that were cited for serious deficiencies in 2006—despite the reforms of OBRA '87 and subsequent efforts by CMS and the nursing home industry to improve the quality of nursing home care. Although there has been an overall decline in the numbers of nursing homes found to have serious deficiencies since fiscal year 2000, variation among states in the proportion of homes with serious deficiencies indicates state survey agencies are not consistently conducting surveys. Challenges associated with the recruitment and retention of state surveyors, combined with increased surveyor workloads, can affect survey consistency. In addition, federal comparative surveys conducted after state surveys found more serious quality-of-care problems than were cited by state surveyors. Although understatement of serious deficiencies identified by federal surveyors in five states has declined since 2004, understatement continues at varying levels across these states.

CMS data indicate an overall decline in reported serious deficiencies from fiscal year 2000 through 2006. The proportion of nursing homes nationwide cited with serious deficiencies declined from 28 percent in fiscal year 2000 to a low of 16 percent in 2004, and then increased to 19 percent in fiscal year 2006 (see fig. 1).

Figure 1: Percentage of Nursing Homes Nationwide with Serious Deficiencies, Fiscal Years 2000-2006



Source: GAO analysis of OSCAR data.

Despite this national trend, significant interstate variation in the proportion of homes with serious deficiencies indicates that states conduct surveys inconsistently. (App. II shows the percentage of homes, by state, cited for serious deficiencies in standard surveys across a 7-year period.). In fiscal year 2006, 6 states identified serious deficiencies in 30 percent or more of homes surveyed, 16 states found such deficiencies in 20 to 30 percent of homes, 22 found these deficiencies in 10 to 19 percent of homes, and 7 found these deficiencies in less than 10 percent of homes. For example, in fiscal year 2006, the percentage of nursing homes cited for serious deficiencies ranged from a low of approximately 2 percent in one state to a high of almost 51 percent in another state.

The inconsistency of state survey findings may reflect challenges in recruiting and retaining state surveyors and increasing state surveyor workloads. We reported in 2005 that, according to state survey agency officials, it is difficult to retain surveyors and fill vacancies because state

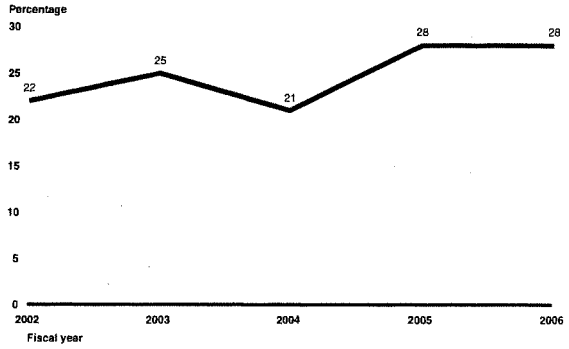
survey agency salaries are rarely competitive with the private sector.[14] Moreover, the first year for a new surveyor is essentially a training period with low productivity. It can take as long as 3 years for a surveyor to gain sufficient knowledge, experience, and confidence to perform the job well. We also reported that limited experience levels of state surveyors resulting from high turnover rates was a contributing factor to (1) variability in citing actual harm or higher-level deficiencies and (2) understatement of such deficiencies. In addition, the implementation of CMS's nursing home initiatives has increased state survey agencies' workload. States are now required to conduct on-site revisits to ensure serious deficiencies have been corrected, promptly investigate complaints alleging actual harm on-site, and initiate off-hour standard surveys in addition to quality-of-care surveys. As a result, surveyor presence in nursing homes has increased and surveyor work hours have effectively been expanded to weekends, evenings, and early mornings.

In addition, data from federal comparative surveys indicate that quality-of-care problems remain for a significant proportion of nursing homes. In fiscal year 2006, 28 percent of federal comparative surveys found more serious deficiencies than did state quality-of-care surveys. Since 2002, federal surveyors have found serious deficiencies in 21 percent or more of comparative surveys that were not cited in corresponding state quality-of-care surveys (see fig. 2). However, some serious deficiencies found by federal, but not state surveyors, may not have existed at the time the state survey occurred.[15]

[14]GAO, *Nursing Homes: Despite Increased Oversight, Challenges Remain in Ensuring High-Quality Care and Resident Safety*, GAO-06-117 (Washington, D.C.: Dec. 28, 2005).

[15]For example, a deficiency noted in a federal survey could involve a resident who was not in the nursing home at the time of the state survey.

Figure 2: Percentage of Federal Comparative Surveys That Noted Serious Deficiencies Not Identified in State Surveys



Source: GAO analysis of OSCAR data.

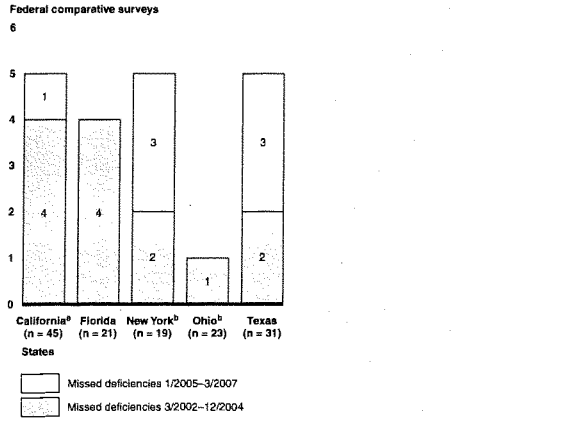
In December 2005, we reported on understatement of serious deficiencies in five states—California, Florida, New York, Ohio, and Texas—from March 2002 through December 2004.[16] We selected these states for our analysis because the percentage of their state surveys that cited serious deficiencies decreased significantly from January 1999 through January 2005.[17] Our analysis of more recent data from these states showed that understatement of serious deficiencies continues at varying levels. Altogether, we examined 139 federal comparative surveys conducted from March 2002 through March 2007 in the five states. Understatement of serious deficiencies decreased from 18 percent for federal comparative surveys during the original time period to 11 percent for federal comparative surveys during the period January 2005 through March 2007.

[16]GAO-06-117. CMS requires its federal surveyors to specifically identify which deficiencies state surveyors missed during the state survey.

[17]These declines in serious deficiencies were 14.3 percentage points for Texas, 15.4 percentage points for Florida, 17.4 percentage points for Ohio, 22.8 percentage points for California, and 23.0 percentage points for New York.

Federal comparative surveys for Florida and Ohio for this most recent time period found that state surveys had not missed any serious deficiencies; however, since 2004 all five states experienced increases in the percentage of homes cited with serious deficiencies on state surveys (see app. II). Understatement of serious deficiencies varied across these five states, as the percentage of serious missed deficiencies ranged from a low of 4 percent in Ohio to a high of 26 percent in New York during the 5-year period March 2002 to March 2007. Figure 3 summarizes our analysis by state, from March 2002 through March 2007.

Figure 3: Federal Comparative Surveys in Five States That Identified Serious Deficiencies Missed by State Surveys, March 2002-March 2007



Source: GAO analysis of federal comparative surveys for five years.

Notes: The total number of federal comparative surveys conducted in each state for the 5-year period, March 2002 to March 2007, is listed in parentheses following the name of the state. The percentage of federal comparative surveys that noted serious deficiencies missed by state surveyors in each state was California, 11 percent; Florida, 19 percent; New York, 26 percent; Ohio, 4 percent; and Texas, 16 percent.

[a]On two comparative surveys, federal surveyors did not provide information on whether any of the deficiencies they identified existed at the time of the state survey; therefore, this number may be understated.

[b]On one comparative survey, federal surveyors did not provide information on whether any of the deficiencies they identified existed at the time of the state survey; therefore, this number may be understated.

CMS Has Strengthened Its Enforcement Capabilities, although Key Initiatives Still Need Refinement

CMS has strengthened its enforcement capabilities since OBRA '87 by, for example, implementing additional sanctions and an immediate sanctions policy for nursing homes found to repeatedly harm residents and developing a new enforcement management data system; however, several key initiatives require refinement. The immediate sanctions policy is complex and appears to have induced only temporary compliance in certain nursing homes with histories of repeated noncompliance. The term "immediate sanctions" is misleading because the policy requires only that homes be notified immediately of CMS's intent to implement sanctions, not that sanctions must be implemented immediately. Furthermore, when a sanction is implemented, there is a lag time between when the deficiency citation occurs and the sanction's effective date. In addition to the immediate sanctions policy, CMS has taken other steps that are intended to address enforcement weaknesses, but their effectiveness remains unclear. Finally, although CMS has developed a new data system, the system's components are not integrated and the national reporting capabilities are incomplete, hampering the agency's ability to track and monitor enforcement.

Despite Changes in Federal Enforcement Policy, Immediate Sanctions Do Not Always Deter Noncompliance and Often Are Not Immediate

Despite CMS's efforts to strengthen federal enforcement policy, it has not deterred some homes from repeatedly harming residents. Effective January 2000, CMS implemented its double G immediate sanctions policy. The policy is complex and does not always appear to deter noncompliance, nor are the sanctions always implemented immediately. We recently reported that the immediate sanctions policy's complex rules, and the exceptions they include, allowed homes to escape immediate sanctions even if they repeatedly harmed residents.[18] CMS acknowledged that the complexity of the policy may be an inherent limitation and indicated that it intends to either strengthen the policy or replace it with a policy that achieves similar goals through alternative methods.

In addition to the complexity of the policy, it does not appear to always deter noncompliance. We recently reported that our review of 63 homes with prior serious quality problems in four states indicated that sanctions may have induced only temporary compliance in these homes because surveyors found that many of the homes with implemented sanctions were

[18]GAO, *Nursing Homes: Efforts to Strengthen Federal Enforcement Have Not Deterred Some Homes from Repeatedly Harming Residents*, GAO-07-241 (Washington, D.C.: Mar. 26, 2007).

again out of compliance on subsequent surveys.[19] From fiscal year 2000 through 2005, 31 of these 63 homes cycled in and out of compliance more than once, harming residents, even after sanctions had been implemented, including 8 homes that did so seven times or more. During this same time period, 27 of the 63 homes were cited 69 times for deficiencies that warranted immediate sanctions, but 15 of these cases did not result in immediate sanctions.[20]

We also recently reported that the term "immediate sanctions" is misleading because the policy is silent on how quickly sanctions should be implemented and there is a lag time between the state's identification of deficiencies during the survey and when the sanction (i.e., a CMP or DPNA) is implemented (i.e., when it goes into effect). The immediate sanctions policy requires that sanctions be imposed immediately. A sanction is considered imposed when a home is notified of CMS's intent to implement a sanction—15 days from the date of the notice. If during the 15-day notice period the nursing home corrects the deficiencies, no sanction is implemented. Thus, nursing homes have a de facto grace period. In addition, there is a lag time between the state's identification of deficiencies and the implementation of a sanction. CMS implemented about 68 percent of the DPNAs for double Gs among the homes we reviewed during fiscal year 2000 through 2005 more than 30 days after the survey.[21] In contrast, CMPs can go into effect as early as the first day the home was out of compliance, even if that date is prior to the survey date because, unlike DPNAs, CMPs do not require a notice period. About 98 percent of CMPs imposed for double Gs took effect on or before the survey date. However, the deterrent effect of CMPs was diluted because CMS imposed CMPs at the lower end of the allowable range for the homes we reviewed. For example, the median per day CMP amount imposed for

[19]GAO-07-241. In this report, we analyzed federal sanctions from fiscal year 2000 through 2005 against 63 nursing homes with a history of harming residents and whose prior compliance and enforcement histories formed the basis for the conclusions in our March 1999 report. The homes were located in California, Michigan, Pennsylvania, and Texas.

[20]In 2003, we reported that we found over 700 cases that should have been referred for immediate sanctions but were not, from January 2000 through March 2002. See GAO, *Nursing Home Quality: Prevalence of Serious Problems, While Declining, Reinforces Importance of Enhanced Oversight*, GAO-03-561 (Washington, D.C.: July 15, 2003).

[21]CMPs and DPNAs accounted for 80 percent of federal sanctions from fiscal year 2000 through 2005. The majority of federal sanctions implemented during this time period—about 54 percent—were CMPs. During this time period, DPNAs and terminations accounted for about 26 percent and less than 1 percent of federal sanctions, respectively.

deficiencies that do not cause immediate jeopardy to residents was $500 in fiscal year 2000 through 2002 and $350 in fiscal year 2003 through 2005; the allowable range is $50 to $3,000 per day.

Although CMPs can be implemented closer to the date of survey than DPNAs, the immediacy and the effect of CMPs may be diminished by (1) the significant time that can pass between the citation of deficiencies on a survey and the home's payment of the CMP and (2) the low amounts imposed, as described earlier. By statute, payment of CMPs is delayed until appeals are exhausted. For example, one home we reviewed did not pay its CMP of $21,600 until more than 2 years after a February 2003 survey had cited a G-level deficiency. This citation was a repeat deficiency: less than a month earlier, the home had received another G-level deficiency in the same quality-of-care area. This finding is consistent with a 2005 report from the Department of Health and Human Services' (HHS) Office of Inspector General that found that the collection of CMPs in appealed cases takes an average of 420 days—a 110 percent increase in time over nonappealed cases—and "consequently, nursing homes are insulated from the repercussions of enforcement by well over a year."[22]

CMS has taken additional steps intended to improve enforcement of nursing home quality requirements; however, the extent to which—or when—these initiatives will address enforcement weaknesses remains unclear. First, to ensure greater consistency in CMP amounts proposed by states and imposed by regions, CMS, in conjunction with state survey agencies, developed a grid that provides guidance for states and regions. The CMP grid lists ranges for minimum CMP amounts while allowing for flexibility to adjust the penalties for factors such as the deficiency's scope and severity, the care areas where the deficiency was cited, and a home's past history of noncompliance. In August 2006, CMS completed the regional office pilot of its CMP grid but had not completed its analysis of the pilot as of April 2007. CMS plans to disseminate the final grid to states soon.[23] Second, in December 2004, CMS expanded the Special Focus Facility program from about 100 homes to include about 135 homes. CMS also modified the program by requiring immediate sanctions for those homes that failed to significantly improve their performance from one

[22]See HHS, Office of Inspector General, *Nursing Home Enforcement: The Use of Civil Money Penalties*, OEI-06-02-00720 (April 2005).

[23]Use of the CMP grid would be optional to provide states flexibility to tailor sanctions to specific circumstances.

survey to the next and by requiring termination for homes with no significant improvement after three surveys over an 18-month period. According to CMS, 11 Special Focus Facilities were terminated in fiscal year 2005 and 7 were terminated in fiscal year 2006. Despite the expansion of the program, many homes that could benefit from enhanced oversight and enforcement are still excluded from the program. For example, of the 63 homes with prior serious quality problems that we recently reviewed, only 2 were designated Special Focus Facilities in 2005, and the number increased to 4 in 2006.

While CMS Collects Valuable Enforcement Data, Its Enforcement Monitoring Data Systems Need Improvement

In March 1999, we reported that CMS lacked a system for effectively integrating enforcement data nationwide and that the lack of such a system weakened oversight. Since 1999, CMS has made progress developing such a system—ASPEN Enforcement Manager (AEM)—and, since October 1, 2004, CMS has used AEM to collect state and regional data on sanctions and improve communications between state survey agencies and CMS regional offices. CMS expects that the data collected in AEM will enable states, CMS regional offices, and the CMS central office to more easily track and evaluate sanctions against nursing homes as well as respond to emerging issues. Developed by CMS's central office primarily for use by states and regions, AEM is one of many modules of a broader data collection system called ASPEN. However, the ASPEN modules—and other data systems related to enforcement such as the financial management system for tracking CMP collections—are fragmented and lack automated interfaces with each other. As a result, enforcement officials must pull discrete bits of data from the various systems and manually combine the data to develop a full enforcement picture.

Furthermore, CMS has not defined a plan for using the AEM data to inform the tracking and monitoring of enforcement through national enforcement reports. While CMS is developing a few such reports, it has not developed a concrete plan and timeline for producing a full set of reports that use the AEM data to help assess the effectiveness of sanctions and its enforcement policies. In addition, while the full complement of enforcement data being recorded by the states and regional offices in AEM is now being uploaded to CMS's national system, CMS does not intend to upload any historical data, which could greatly enhance enforcement monitoring efforts. Finally, AEM has quality control weaknesses, such as the lack of systematic quality control mechanisms to ensure accuracy of data entry.

CMS officials told us they will continue to develop and implement enhancements to AEM to expand its capabilities over the next several years. However, until CMS develops a plan for integrating the fragmented systems and for using AEM data—along with other data the agency collects—efficient and effective tracking and monitoring of enforcement will continue to be hampered. As a result, CMS will have difficulty assessing the effectiveness of sanctions and its enforcement policies.[24]

CMS Has Strengthened Oversight, although Competing Priorities Impede Certain Key Initiatives

CMS oversight of nursing home quality and state surveys has increased significantly through several efforts, but CMS initiatives for nursing home quality oversight continue to compete with each other, as well as with other CMS programs, for staff and financial resources. Since OBRA '87 required CMS to annually conduct federal monitoring surveys for a sample of nursing homes to test the adequacy of state surveys, CMS has developed a number of initiatives to strengthen its oversight. These initiatives have increased federal surveyors' workload and the demand for resources. Greater demand on limited resources has led to queues and delays in certain key initiatives. In particular, the implementation of three key initiatives—the new Quality Indicator Survey (QIS), investigative protocols for quality-of-care problems, and an increase in the number of federal quality-of-care comparative surveys—was delayed because they compete for priority with other CMS projects.

Intensity of Federal Efforts Has Increased Significantly

CMS has used both federal monitoring surveys and annual state performance reviews to increase its oversight of quality of care in nursing homes. Through these two mechanisms it has focused its resources and attention on (1) prompt investigation of complaints and allegations of abuse, (2) more frequent and timely federal comparative surveys, (3) stronger fire safety standards, and (4) upgrades to data systems.

Complaint Investigations

To ensure that complaints and allegations of abuse are investigated and addressed in accordance with OBRA '87, CMS has issued guidance and taken other steps. CMS guidance issued since 1999 has helped strengthen state procedures for investigating complaints. For example, CMS instructed states to investigate complaints alleging harm to a resident

[24]We recently recommended that the Administrator of CMS undertake a number of steps to strengthen enforcement capabilities. CMS generally concurred with our recommendations, although it pointed out some resource constraints to implementing certain ones. See GAO-07-241.

within 10 workdays; previously states could establish their own time frames for complaints at this level of severity. In addition, CMS guidance to states in 2002 and 2004 clarified policies on reporting abuse, including requiring notification of local law enforcement and Medicaid Fraud Control Units, establishing time frames, and citing abuse on surveys.

CMS has taken three additional steps to improve its oversight of state complaint investigations, including allegations of abuse. First, in its annual state performance reviews implemented in 2002, it required that federal surveyors review a sample of complaints in each state.[25] These reviews were done to determine whether states (1) properly categorized complaints in terms of how quickly they should be investigated, (2) investigated complaints within the time specified, and (3) properly included the results of the investigations in CMS's database. Second, in January 2004, CMS implemented a new national automated complaint tracking system, the ASPEN Complaints and Incidents Tracking System. The lack of a national complaint reporting system had hindered CMS's and states' ability to adequately track the status of complaint investigations and CMS's ability to maintain a full compliance history on each nursing home. Third, in November 2004, CMS requested state survey agency directors to self-assess their states' compliance with federal requirements for maintaining and operating nurse aide registries. CMS has not issued a formal report of findings from these assessments, but in 2005 we reported that CMS officials noted that resource constraints have impeded states' compliance with certain federal requirements.[26] As a part of this effort, CMS is also conducting a Background Check Pilot Program. The pilot program will test the effectiveness of state and national fingerprint-based background checks on employees of long-term care facilities, including nursing homes.[27]

Federal Comparative Surveys

CMS has increased the number of federal comparative surveys for both quality of care and fire safety and decreased the time between the end of the state survey and the start of the federal comparative surveys. These improvements allow CMS to better distinguish between serious problems

[25]Annual state performance reviews were established in fiscal year 2001 and fully implemented in fiscal year 2002.

[26]GAO-06-117.

[27]Pilot programs have been phased in from fall 2005 through September 2007 in seven states—Alaska, Idaho, Illinois, Michigan, Nevada, New Mexico, and Wisconsin. An independent evaluation is expected in spring 2008.

missed by state surveyors and changes in the home that occurred after the state survey. The number of comparative quality-of-care surveys nationwide per year increased from about 10 surveys a year during the 24-month period prior to October 1998 to about 160 per year for fiscal years 2005 and 2006.[28] The number of fire safety comparative surveys increased as well from 40 in fiscal year 2003 to 536 in fiscal year 2006. In addition, the average elapsed time between state and comparative quality-of-care surveys has decreased from 33 calendar days for the 64 comparative surveys we reviewed in 1999 to 26 days for all federal comparative surveys completed through fiscal year 2006.

Fire Safety Standards

In addition to conducting more frequent federal comparative surveys for fire safety, CMS has strengthened fire safety standards. In response to a recommendation in our July 2004 report to strengthen fire safety standards,[29] CMS issued a final rule in September 2006 requiring nonsprinklered nursing homes to install battery-powered smoke detectors in resident rooms and common areas.[30] In addition, CMS has issued a proposed rule that would require all nursing homes to be equipped with sprinkler systems and, after reviewing public comment, intends to publish a final version of the rule and stipulate an effective date for all homes to comply.[31]

Upgrades to Data Systems

CMS has pursued important upgrades to data systems, expanded dissemination of data and information, and addressed accuracy issues in the MDS in addition to implementing complaint and enforcement systems. One such upgrade increased state and federal surveyors' access to OSCAR data. CMS now uses OSCAR data to produce periodic reports to monitor both state and federal survey performance. Some reports, such as survey timeliness, are used during state performance reviews, while others are intended to help identify problems or inconsistencies in state survey

[28]As of fiscal year 2006, there were about 16,000 nursing homes which would require over 800 federal monitoring surveys. Since 1992 when all federal monitoring surveys were comparative, CMS has begun to rely more heavily on observational surveys, which require a smaller number of federal surveyors. In fiscal year 2006, roughly 77 percent of federal monitoring surveys were observational.

[29]GAO, *Nursing Home Fire Safety: Recent Fires Highlight Weaknesses in Federal Standards and Oversight*, GAO-04-660 (Washington D.C.: July 16, 2004).

[30]71 Fed. Reg. 55326 (Sept. 22, 2006) (codified in pertinent part at 42 C.F.R. §483.70). CMS began surveying nursing homes' compliance with the new requirement in May 2006.

[31]71 Fed. Reg. 62957 (Oct. 27, 2006) (to be codified at 42 C.F.R. §483.70).

activities and the need for intervention. In addition, CMS created a Web-accessible software program called Providing Data Quickly (PDQ) that allows regional offices and state survey agencies easier access to standard OSCAR reports, including one that identifies the homes that have repeatedly harmed residents and meet the criteria for imposition of immediate sanctions.

Since launching its Nursing Home Compare Web site in 1998, CMS has expanded its dissemination of information to the public on individual nursing homes participating in Medicare or Medicaid.[32] In addition to data on any deficiencies identified during standard surveys, the Web site now includes data on the results of complaint investigations, information on nursing home staffing levels, and quality measures, such as the percentage of residents with pressure sores. On the basis of our recommendations, CMS is now reporting fire safety deficiencies on the Web site, including information on whether a home has automatic sprinklers to suppress a fire, and may include information on impending sanctions in the future. However, CMS continues to address ongoing problems with the accuracy and reliability of some of the underlying data. For example, CMS has evaluated the validity of quality measures and staffing information it makes available on the Web, and it has removed or excluded questionable data.

In addition to building the quality measures reported on Nursing Home Compare, the MDS data are the basis for patient care plans, adjusting Medicare nursing home payments as well as Medicaid payments in some states, and assisting with quality oversight. Thus the accuracy of the MDS has implications for the identification of quality problems and the level of nursing home payments. OBRA '87 required nursing homes that participate in the Medicare and Medicaid programs to perform periodic resident assessments; these resident assessments are known as the MDS. In February 2002, we assessed federal government efforts to ensure the accuracy of the MDS data.[33] We reported that on-site reviews of MDS data that compared the MDS to supporting documentation were a very effective method of assessing the accuracy of the data. However, CMS's efforts to ensure the accuracy of the underlying MDS data were too reliant on off-site reviews, which were limited to documentation reviews or data

[32]http://www.medicare.gov/NHCompare/home.asp.

[33]GAO, *Nursing Homes: Federal Efforts to Monitor Resident Assessment Data Should Complement State Activities*, GAO-02-279 (Washington, D.C.: Feb. 15, 2002).

analysis. To ensure the accuracy of the MDS, CMS signed a new contract for on-site reviews in September 2005; these reviews are ongoing.

Competing Priorities Impede Certain Key CMS Initiatives

CMS initiatives for nursing home quality oversight continue to compete with each other, as well as with other CMS programs, for staff and financial resources. Greater nursing home oversight and growth in the number of Medicare and Medicaid providers has created increased demand for staff and financial resources. Greater demand on limited resources has led to queues and delays in key initiatives. Three key initiatives—the new Quality Indicator Survey (QIS), investigative protocols for quality-of-care problems, and an increase in the number of federal quality-of-care comparative surveys—were delayed because they compete for priority with other CMS projects.

The implementation of the QIS, in process for over 8 years, continues to encounter delays because of a lack of resources. The QIS is a two-stage, data-driven, structured survey process intended to systematically target potential problems at nursing homes by using an expanded sample and structured interviews to help surveyors better assess the scope of any identified deficiencies. CMS is currently concluding a five-state demonstration of the QIS system. A preliminary evaluation by CMS indicates that surveyors have spent less time in homes that are performing well, deficiency citations were linked to more defensible documentation, and serious deficiencies were more frequently cited in some demonstration states. However, CMS officials recently reported that resource constraints in fiscal year 2007 threaten the planned expansion of this process beyond the five demonstration states. Although 13 states applied to transition to QIS, resource limitations may prevent this expansion. In addition, at least $2 million is needed over 2 years to develop a production quality software package for the QIS.

Since hiring a contractor in 2001 to facilitate convening expert panels for the development and review of new investigative protocols, CMS has implemented eight sets of investigative protocols. In December 2005, we reported that these investigative protocols provided surveyors with detailed interpretive guidance and ensured greater rigor in on-site investigations of specific quality-of-care areas, such as pressure sores, incontinence, and medical director qualifications. However, the issuance of additional protocols was slowed because of lengthy consultation with experts and prolonged delays related to internal disagreement over the structure of the process. Instead, it has returned to the traditional revision process even though agency staff believes that the expert panel process

produced a high-quality product. Since issuing several protocols in 2006, CMS has plans to issue two additional protocols.

Although CMS hired a contractor in 2003 to further increase the number of federal quality-of-care comparative surveys, it stopped funding this initiative in fiscal year 2006. The agency reallocated the funds to help state survey agencies meet the increased workload resulting from growth in the number of other Medicare providers.

Concluding Observations

About 20 years ago, significant attention from the Special Committee on Aging, the Institute of Medicine, and others served as a catalyst to focus national attention on nursing home quality issues, culminating in the nursing home reform provisions of OBRA '87. Beginning in 1998, the Committee again served as a catalyst to focus national attention on the fact that the task was not complete; through a series of hearings, it held the various stakeholders publicly accountable for the substandard care reported in a small but significant share of nursing homes nationwide. Since then, in response to many GAO recommendations and on its own initiative, CMS has taken many important steps and invested resources to respond in a timelier, more rigorous, and more consistent manner to identified problems and improve its oversight process for the care of vulnerable nursing home residents. This is admittedly no small undertaking, given the large number and diversity of stakeholders and caregivers involved at the federal, state, and provider levels. Nevertheless, despite the passage of time and the level of investment and effort, the work begun after OBRA '87 is still not complete. It is important to continue to focus national attention on and ensure public accountability for homes that harm residents. With these ongoing efforts, the momentum of earlier initiatives can be sustained and perhaps even enhanced and the quality of care for nursing home residents can be secured, as intended by Congress when it passed this legislation.

Mr. Chairman, this concludes my prepared remarks. I would be pleased to respond to any questions that you or other Members of the Committee may have.

GAO Contact and Acknowledgments

For future contacts regarding this testimony, please contact Kathryn G. Allen at (202) 512-7118 or at allenk@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this testimony. Walter Ochinko, Assistant Director; Kaycee M. Glavich; Leslie V. Gordon; K. Nicole Haeberle; Daniel Lee; and Elizabeth T. Morrison made key contributions to this statement.

Appendix I: Prior GAO Recommendations, Related CMS Initiatives, and Implementation Status

Table 2 summarizes our recommendations from 11 reports on nursing home quality and safety, issued from July 1998 through March 2007; CMS's actions to address weaknesses we identified; and the implementation status of CMS's initiatives as of April 2007. The recommendations are grouped into four categories—surveys, complaints, enforcement, and oversight. If a report contained recommendations related to more than one category, the report appears more than once in the table. For each report, the first two numbers identify the fiscal year in which the report was issued. For example, HEHS-98-202 was released in 1998. The Related GAO Products section at the end of this statement contains the full citation for each report. Of our 42 recommendations, CMS has fully implemented 18, implemented only parts of 7, is taking steps to implement 10, and declined to implement 7.

Table 2: Implementation Status of CMS's Initiatives Responding to GAO's Nursing Home Quality and Safety Recommendations, July 1998 through April 2007

GAO report number	GAO recommendation	CMS initiative	Implementation status
Surveys			
GAO/HEHS-98-202	1. Stagger or otherwise vary the scheduling of standard surveys to effectively reduce the predictability of surveyors' visits. The variation could include segmenting the standard survey into more than one review throughout the 12- to 15-month period, which would provide more opportunities for surveyors to observe problematic homes and initiate broader reviews when warranted.	CMS took several steps to reduce survey predictability, but some state surveys remain predictable. • In 1999, CMS instructed state survey agencies to (1) conduct 10 percent of surveys on evenings and weekends, (2) vary the sequencing of surveys in a geographical area to avoid alerting other homes that the surveyors are in the area, (3) vary the scheduling of surveys by day of the week, and (4) avoid scheduling surveys for the same month as a home's prior survey. • In 2004, CMS provided states with an automated scheduling and tracking system (AST) to assist in scheduling surveys. CMS officials told us that AST can be used to address survey predictability. States appeared to be unaware of this feature and use of AST is optional. • CMS disagreed with and did not implement the recommendation to segment the standard survey into more than one review throughout the 12- to 15-month period.	◑

GAO report number	GAO recommendation	CMS initiative	Implementation status
	2. Revise federal survey procedures to instruct surveyors to take stratified random samples of resident cases and review sufficient numbers and types of resident cases so that surveyors can better detect problems and assess their prevalence.	CMS has been developing a revised survey methodology since 1998. A pilot test of the new methodology began in the fall of 2005. Implementation could begin in mid-2007.	○
GAO-03-561	3. Finalize the development, testing, and implementation of a more rigorous survey methodology, including investigative protocols that provide guidance to surveyors in documenting deficiencies at the appropriate scope and severity level.	See CMS action in response to recommendation to revise federal survey procedures (recommendation #2 above). CMS began revising surveyors' investigative protocols in October 2000. Eight protocols have been issued, and two additional protocols are under development. Due to issues with interpretation, CMS is no longer planning to issue definitions of actual harm and immediate jeopardy outside of the regulations.	○
	4. Require states to have a quality assurance process that includes, at a minimum, a review of a sample of survey reports below the level of actual harm to assess the appropriateness of the scope and severity cited and to help reduce instances of understated quality-of-care problems.	CMS has no plans to implement this recommendation, indicating that regular workload and priorities take precedence over it.	⊗
GAO-05-78	5. Hold homes accountable for all past noncompliance resulting in harm to residents, not just care problems deemed to be egregious, and develop an approach for citing such past noncompliance in a manner that clearly identifies the specific nature of the care problem both in the OSCAR database and on CMS's Nursing Home Compare Web site.	CMS revised its definition of past noncompliance. While CMS has not ruled out placing enforcement information on its Nursing Home Compare Web site in the future, CMS officials told us that resource constraints limit the agency's ability to do so at the current time.	○
Complaints			
GAO/HEHS-99-80	6. Develop additional standards for the prompt investigation of serious complaints alleging situations that may harm residents but are categorized as less than immediate jeopardy. These standards should include maximum allowable time frames for investigating serious complaints and for complaints that may be deferred until the next scheduled annual survey. States may continue to set priority levels and time frames that are more stringent than these federal standards.	In October 1999, CMS issued a policy letter stating that complaints alleging harm must be investigated within 10 days. In January 2004, CMS provided detailed direction and guidance to states for managing complaint investigations for numerous types of providers, including nursing homes. In June 2004, CMS made available updated guidance on the Internet that consolidates complaint investigation procedures for numerous types of providers.	●

GAO report number	GAO recommendation	CMS initiative	Implementation status
	7. Strengthen federal oversight of state complaint investigations, including monitoring states' practices regarding priority-setting, on-site investigation, and timely reporting of serious health and safety complaints.	In 2000, CMS began requiring its regional offices to perform yearly assessments of states' complaint investigations as part of annual state performance reviews.	●
GAO-03-561	8. Finalize the development of guidance to states for their complaint investigation processes and ensure that it addresses key weaknesses, including the prioritization of complaints for investigation, particularly those alleging harm to residents; the handling of facility self-reported incidents; and the use of appropriate complaint investigation practices.	In January 2004, CMS provided detailed direction and guidance to states for managing complaint investigations for numerous types of providers, including nursing homes. In June 2004, CMS made available updated guidance on the Internet that consolidates complaint investigation procedures for numerous types of providers.	●
GAO-02-312	9. Ensure that state survey agencies immediately notify local law enforcement agencies or Medicaid Fraud Control Units when nursing homes report allegations of resident physical or sexual abuse or when the survey agency has confirmed complaints of alleged abuse.	In 2002, CMS issued a memorandum to the regional offices and state survey agencies emphasizing its policy for preventing abuse in nursing homes and for promptly reporting it to the appropriate agencies when it occurs. CMS determined it does not have the legal authority to require state survey agencies to report suspected physical and sexual abuse of nursing home residents.	◑
	10. Accelerate the agency's education campaign on reporting nursing home abuse by (1) distributing its new poster with clearly displayed complaint telephone numbers and (2) requiring state survey agencies to ensure that these numbers are prominently listed in local telephone directories.	In 2002, CMS released a memorandum to regional offices and state agencies that addresses displaying complaint telephone numbers. CMS asked all state agencies to review how their telephone number is listed in the local directory and asked them to ensure that their complaint telephone numbers are prominently listed. In 2007, CMS officials told us that it has not and is not likely to release the poster.	◑
	11. Systematically assess state policies and practices for complying with the federal requirement to prohibit employment of individuals convicted of abusing nursing home residents and, if necessary, develop more specific guidance to ensure compliance.	CMS is conducting a Background Check Pilot Program in several states, as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The pilot is expected to run through September 2007 and will be followed by an independent evaluation. The final study is targeted for submission by spring of 2008.	○

GAO report number	GAO recommendation	CMS initiative	Implementation status
	12. Clarify the definition of abuse and otherwise ensure that states apply that definition consistently and appropriately.	In 2002, CMS released a memorandum to its regional offices and state survey agency directors clarifying its definition of abuse and instructing them to report suspected abuse to law enforcement authorities and, if appropriate, to the state's Medicaid Fraud Control Unit.[a]	●
	13. Shorten the state survey agencies' time frames for determining whether to include findings of abuse in nurse aide registry files.	CMS informed GAO that federal regulations specify that if an investigation finds an individual has neglected or abused a resident or misappropriated resident property, the state must report the findings in writing within 10 working days to the nurse aide registry. However, CMS stated it does not specify a time frame for completion of such investigations due to concerns that a time limit could compromise complaint investigations in some instances.	◑
Enforcement			
GAO/HEHS-98-202	14. Require that for problem homes with recurring serious violations, state surveyors substantiate, by means of an on-site revisit, every report to CMS of a home's resumed compliance status.	In 1998, CMS issued guidance to regional offices and state survey agencies strengthening its revisit policy by requiring on-site revisits until all serious deficiencies are corrected. Homes are no longer permitted to self-report resumed compliance.	●
	15. Eliminate the grace period for homes cited for repeated serious violations and impose sanctions promptly, as permitted under existing regulations.	CMS phased in implementation of its double G policy from September 1998 through January 2000.	●
GAO/HEHS-99-46	16. Improve the effectiveness of civil monetary penalties: The Administrator should continue to take those steps necessary to shorten the delay in adjudicating appeals, including monitoring progress made in reducing the backlog of appeals.	As requested by HHS, Congress approved increased funding and staffing levels for the Departmental Appeals Board in fiscal years 1999 and 2000.	●
	17. Strengthen the use and effect of termination:		◑
	• Continue Medicare and Medicaid payments beyond the termination date only if the home and state Medicaid agency are making reasonable efforts to transfer residents to other homes or alternative modes of care.	CMS conducted a study and concluded that it was not practical to establish rules to address this problem.	

GAO report number	GAO recommendation	CMS initiative	Implementation status
	• Ensure that reasonable assurance periods associated with reinstating terminated homes are of sufficient duration to effectively demonstrate that the reason for termination has been resolved and will not recur.	CMS added examples to the reasonable assurance guidance in 2000, but declined to lengthen the reasonable assurance period.	
	• Strengthen the use and effect of termination: Revise existing policies so that the pretermination history of a home is considered in taking a subsequent enforcement action.	In 2000, CMS revised its guidance so that pretermination history of a home is considered in taking subsequent enforcement actions.	
	18. Improve the referral process: The Administrator should revise CMS guidance so that states refer homes to CMS for possible sanction (such as civil monetary penalties) if they have been cited for a deficiency that contributed to a resident's death.	In 2000, CMS revised its guidance to require states to refer homes for possible sanction if they had been cited for a deficiency that contributed to a resident's death.	●
GAO-07-241	19. Reassess and revise the immediate sanctions policy to ensure that it accomplishes the following:	CMS acknowledged that the complexity of its immediate sanctions policy may be an inherent limitation and indicated that it intends to either strengthen the policy or replace it with a policy that achieves similar goals through alternative methods.	○
	• Reduce the lag time between citation of a double G and the implementation of a sanction.	CMS agreed to reduce the lag time between citation and implementation of a double G immediate sanction by limiting the prospective effective date for DPNAs to no more than 30 to 60 days.	
	• Prevent nursing homes that repeatedly harm residents or place them in immediate jeopardy from escaping sanctions.	CMS indicated it will remove the limitation in the double G policy on applying an additional sanction simply because a nursing home has not completed corrections to a deficiency that gave rise to a previous sanction.	
	• Hold states accountable for reporting in federal data systems serious deficiencies identified during complaint investigations so that all complaint findings are considered in determining when immediate sanctions are warranted.	CMS agreed to collect additional information on complaints for which data are not reported in federal data systems.	
	20. Strengthen the deterrent effect of available sanctions and ensure that sanctions are used to their fullest potential:		○
	• Ensure the consistency of CMPs by issuing guidance, such as the standardized CMP grid piloted during 2006.	CMS agreed to issue a CMP analytic tool, or grid, and to provide states with further guidance on discretionary DPNAs and terminations.	

GAO report number	GAO recommendation	CMS initiative	Implementation status
	• Increase use of discretionary DPNAs to help ensure the speedier implementation of appropriate sanctions.	CMS indicated it will issue further guidance for states on factors to be considered in determining whether a discretionary DPNA is imposed or a termination date is set earlier than the time periods required by law	
	• Strengthen the criteria for terminating homes with a history of serious, repeated noncompliance by limiting the extension of termination dates, increasing the use of discretionary terminations, and exploring alternative thresholds for termination, such as the cumulative duration of noncompliance.	CMS stated it will work with states, consumer organizations, stakeholders, and others to design proposals for a better combination of enforcement actions for homes with repeated quality-of-care deficiencies.	
	21. Develop an administrative process under which CMPs would be paid—or Medicare and Medicaid payments in equivalent amounts would be withheld—prior to exhaustion of appeals and seek legislation for the implementation of this process, as appropriate.	CMS agreed to seek legislative authority to collect CMPs prior to the exhaustion of appeals.	○
	22. Further expand the Special Focus Facility program with enhanced enforcement requirements to include all homes that meet a threshold to qualify as poorly performing homes.	CMS agreed with the concept of expanding the Special Focus Facility program to include all homes that meet a threshold qualifying them as poorly performing homes, but said it lacks the resources needed for this expansion. CMS also identified other initiatives it will implement to improve the program.	○
	23. Improve the effectiveness of the new enforcement data system:		○
	• Develop the enforcement-related data systems' abilities to interface with each other in order to improve the tracking and monitoring of enforcement.	CMS agreed to study the feasibility of linking the separate data systems used for enforcement; however, it indicated that available resources may limit further action.	
	• Expedite the development of national enforcement reports and a concrete plan for using the reports.	CMS agreed to study the feasibility of developing national standard enforcement reports, but stated thet further action on these reports may be limited by resource availability.	
	• Develop and institute a system of quality checks to ensure the accuracy and integrity of AEM data.	CMS agreed to develop and implement a system of quality checks to ensure the accuracy of its data systems, including AEM.	
	24. Expand CMS's Nursing Home Compare Web site to include implemented sanctions and homes subjected to immediate sanctions.	CMS proposed reporting implemented sanctions only for poorly performing homes that meet an undefined threshold—this is not fully responsive to our recommendation.	◑

GAO report number	GAO recommendation	CMS initiative	Implementation status
Oversight			
GAO/HEHS-99-46	25. Develop better management information systems. The Administrator should enhance OSCAR or develop some other information system that can be used by both by the states and CMS to integrate the results of complaint investigations, track the status and history of deficiencies, and monitor enforcement actions.	CMS has implemented new national enforcement and complaint tracking systems but has delayed its replacement of the OSCAR data system until 2009 as a result of funding cuts and CMS focus on other initiatives.	○
GAO/HEHS-99-80	26. Require that the substantiated results of complaint investigations be included in federal data systems or be accessible by federal officials.	In January 2004, CMS's new ASPEN Complaint Tracking system was implemented nationwide.	●
GAO/HEHS-00-6	27. Improve the scope and rigor of CMS's oversight process:		●
	• Increase the proportion of federal monitoring surveys conducted as comparative surveys to ensure that a sufficient number are completed in each state to assess whether the state appropriately identifies serious deficiencies.	CMS has significantly increased the number of quality-of-care comparative surveys. In fiscal year 2006, however, the agency will no longer contract for additional quality-of-care comparative surveys because of funding constraints.	
	• Ensure that comparative surveys are initiated closer to the time the state agency completes the home's annual standard survey.	To better ensure that conditions in a nursing home have not changed since the state survey, CMS regional offices reduced the average time between the state survey and the initiation of a federal comparative survey from 33 days in 1999 to 26 days by 2004.	
	• Require regions to provide more timely written feedback to the states after the completion of federal monitoring surveys.	CMS instructed the regions to report the results of federal monitoring surveys to states on a monthly basis.	
	• Improve the data system for observational surveys so that it is an effective management tool for CMS to properly assess the findings of observational surveys.	CMS developed a separate database accessible to all regional offices that includes the results of observational surveys. Beginning in fiscal year 2002, CMS added data on the results of comparative surveys.	
	28. Improve the consistency in how CMS holds state survey agencies accountable by standardizing procedures for selecting state surveys and conducting federal monitoring surveys:		◑
	• Ensure that the regions target surveys for review that will provide a comprehensive assessment of state surveyor performance.	CMS did not implement our recommendation to select individual state surveys for federal review in a manner that ensures its regional offices observe as many state surveyors as possible.	

GAO report number	GAO recommendation	CMS initiative	Implementation status
	• Require federal surveyors to include as many of the same residents as possible in their comparative survey sample as the state included in its sample (where CMS surveyors have determined that the state sample selection process was appropriate).	In October 2002, CMS instructed federal surveyors to select at least half of those residents selected by the state surveyors for their resident sample.	
	29. Further explore the feasibility of appropriate alternative remedies or sanctions for those states that prove unable or unwilling to meet CMS's performance standards.	In December 1999, CMS adopted new state sanctions. In fiscal year 2005, CMS began to tie survey agency funding increases to the timely conduct of standard surveys, a step that we believe offers a strong incentive for improved compliance.	●
GAO/HEHS-02-279	30. Review the adequacy of current state efforts to ensure the accuracy of minimum data set (MDS) data, and provide, where necessary, additional guidance, training, and technical assistance.	CMS disagreed with and did not implement this recommendation.	⊗
	31. Monitor the adequacy of state MDS accuracy activities on an ongoing basis, such as through the use of the established federal comparative survey process.	CMS disagreed with and did not implement this recommendation.	⊗
	32. Provide guidance to state agencies and nursing homes that sufficient evidentiary documentation to support the full MDS assessment be included in residents' medical records.	CMS disagreed with and did not implement this recommendation.	⊗
GAO-03-187	33. Delay the implementation of nationwide reporting of quality indicators until there is greater assurance that the quality indicators are appropriate for public reporting—including the validity of the indicators selected and the use of an appropriate risk-adjustment methodology—based on input from the National Quality Forum end other experts and, if necessary, additional analysis and testing.	CMS disagreed with and did not implement this recommendation.	⊗
	34. Delay the implementation of nationwide reporting of quality indicators until a more thorough evaluation of the pilot is completed to help improve the initiative's effectiveness, including an assessment of the presentation of information on the Web site and the resources needed to assist consumers' use of the information.	CMS disagreed with and did not implement this recommendation.	⊗

GAO report number	GAO recommendation	CMS initiative	Implementation status
GAO-03-561	35. Further refine annual state performance reviews so that they (1) consistently distinguish between systemic problems and less serious issues regarding state performance, (2) analyze trends in the proportion of homes that harm residents, (3) assess state compliance with the immediate sanctions policy for homes with a pattern of harming residents, and (4) analyze the predictability of state surveys.	CMS did not implement this recommendation because it believes that the state performance standards take into account statutory and nonstatutory performance standards.	⊗
GAO-04-660	36. Ensure that CMS regional offices fully comply with the statutory requirement to conduct annual federal monitoring surveys by including an assessment of the fire safety component of states' standard surveys, with an emphasis on unsprinklered homes.	CMS's evaluation of state surveyors' performance now routinely includes fire safety as part of the statutory requirement to annually conduct federal monitoring surveys in at least 5 percent of surveyed nursing homes in each state.	●
	37. Ensure that data on sprinkler coverage in nursing homes are consistently obtained and reflected in the CMS database.	CMS now obtains the sprinkler status of over 99 percent of nursing homes during routine surveys and inputs this information into OSCAR.	●
	38. Until sprinkler coverage data are routinely available in CMS's database, work with state survey agencies to identify the extent to which each nursing home is sprinklered or not sprinklered.	See CMS action in response to recommendation for ensuring that data on sprinkler coverage in nursing homes are consistently obtained (recommendation #37 above).	●
	39. On an expedited basis, review all waivers and Fire Safety Evaluation System (FSES) assessments for homes that are not fully sprinklered to determine their appropriateness.[b]	CMS has completed reviews of all waiver requests and FSES assessments and noted that the number of homes using FSES dropped significantly as a result of the review.	●
	40. Make information on fire safety deficiencies available to the public via the Nursing Home Compare Web site, including information on whether a home has automatic sprinklers.	This information was made available on the Nursing Home Compare Web site as of October 2006.	●
	41. Work with the National Fire Protection Association to strengthen fire safety standards for unsprinklered nursing homes, such as requiring smoke detectors in resident rooms, exploring the feasibility of requiring sprinklers in all nursing homes, and developing a strategy for financing such requirements.	CMS issued regulations effective May 24, 2005, requiring nursing facilities to install smoke detectors in resident rooms and public areas if they do not have a sprinkler system installed throughout the facility or a hard-wired smoke detection system in those areas. Facilities were given 1 year, until May 24, 2006, to comply with this requirement. In addition, the National Fire Protection Association approved a revision to the 2006 Life Safety Code which requires the installation of automatic sprinkler systems in all existing facilities.	●

GAO report number	GAO recommendation	CMS initiative	Implementation status
	42. Ensure that thorough investigations are conducted following multiple-death nursing home fires so that fire safety standards can be reevaluated and modified where appropriate.	CMS developed and issued a standardized procedure to ensure that both state survey agencies and its own staff take appropriate action to investigate fires that result in serious injury or death.	●

(●) Fully implemented our recommendation

(◑) Implemented only part of our recommendation and no further steps are planned

(○) Taking steps to implement our recommendation

(⊗) Did not implement our recommendation

Source: GAO analysis of CMS's responses to our recommendations.

[a]In 1999, CMS had required the use of an investigative protocol on abuse prohibition during every standard survey. The protocol's objective is to determine if the facility has developed and operationalized policies and procedures that prohibit abuse, neglect, involuntary seclusion, and misappropriation of resident property.

[b]As an alternative to correcting or receiving a waiver for deficiencies identified on a standard survey, a home may undergo an assessment using the Fire Safety Evaluation System. The system provides a means for nursing homes to meet the fire safety objectives of CMS's standards without necessarily being in full compliance with every standard.

Appendix II: Percentage of Nursing Homes Cited for Actual Harm or Immediate Jeopardy during Standard Surveys

In order to identify trends in the percentage of nursing homes cited with actual harm or immediate jeopardy deficiencies, we analyzed data from CMS's OSCAR database for fiscal years 2000 through 2006 (see table 3). Because surveys are conducted at least every 15 months (with a required 12-month statewide average), it is possible that a home was surveyed twice in any time period. To avoid double counting of homes, we included only homes' most recent survey from each period.

Table 3: Percentage of Nursing Homes Cited for Actual Harm or Immediate Jeopardy, by State, Fiscal Years 2000-2006

		Fiscal year						
State	Number of homes 2006	2000	2001	2002	2003	2004	2005	2006
Alabama	231	35.5	23.0	12.7	18.1	15.6	23.1	24.2
Alaska	15	28.6	26.7	26.7	0.0	0.0	0.0	26.7
Arizona	135	24.2	12.6	7.3	6.6	9.4	9.9	24.8
Arkansas	245	38.1	27.7	22.3	24.7	19.5	15.9	14.5
California	1,304	24.1	10.9	5.1	3.7	6.1	8.0	14.1
Colorado	215	20.4	26.4	32.7	20.9	25.9	40.4	44.8
Connecticut	245	41.9	51.6	45.8	43.1	54.4	44.2	50.8
Delaware	44	47.5	14.6	10.8	5.3	15.0	35.7	36.8
District of Columbia	20	17.7	28.6	30.0	41.2	40.0	30.0	25.0
Florida	688	22.8	20.2	14.9	10.2	7.8	4.2	9.1
Georgia	371	19.5	21.0	23.7	24.6	16.6	18.0	15.9
Hawaii	48	23.8	14.3	21.2	12.1	22.9	2.8	2.1
Idaho	80	51.4	29.7	39.2	31.9	27.3	38.4	47.8
Illinois	816	28.4	19.2	15.3	18.3	15.1	15.7	21.7
Indiana	526	45.0	29.4	23.2	19.7	24.1	28.3	33.4
Iowa	466	14.7	12.0	8.0	9.1	11.8	11.2	11.7
Kansas	361	37.9	30.7	32.9	26.5	30.3	34.9	38.3
Kentucky	298	26.8	29.1	23.2	26.1	14.6	7.7	11.4
Louisiana	307	21.8	29.9	21.7	16.2	12.0	15.4	15.8
Maine	114	11.1	13.9	6.6	11.1	12.8	7.0	9.8
Maryland	235	22.4	16.5	26.1	15.4	17.8	7.6	7.6
Massachusetts	456	29.1	24.4	24.6	25.9	16.7	22.6	20.9
Michigan	429	42.8	24.5	29.7	26.9	22.9	22.9	29.7
Minnesota	404	30.4	17.3	22.3	18.3	14.3	14.4	18.8
Mississippi	207	33.0	19.8	18.7	16.0	18.9	18.1	9.4
Missouri	526	19.8	13.0	15.6	12.5	11.7	15.4	15.6

Montana	97	33.3	29.7	12.0	20.0	18.0	17.9	16.7
Nebraska	229	19.2	21.1	20.1	14.8	15.3	14.4	25.7
Nevada	47	34.8	14.6	11.9	9.1	17.5	19.6	21.3
New Hampshire	83	37.8	31.1	29.4	24.1	25.6	26.3	22.9
New Jersey	363	25.5	27.8	18.8	10.5	13.5	18.2	15.5
New Mexico	75	23.7	16.9	14.9	21.3	24.3	29.4	25.0
New York	658	33.8	37.1	34.2	15.2	11.0	14.0	18.5
North Carolina	424	43.6	35.8	25.6	29.0	21.1	18.5	17.2
North Dakota	83	25.9	28.7	17.9	12.4	13.6	17.7	21.7
Ohio	980	26.6	27.3	25.4	19.1	11.4	13.8	14.6
Oklahoma	359	19.3	21.3	22.0	26.3	13.9	23.2	20.1
Oregon	142	45.5	32.6	23.7	20.3	15.9	19.8	18.6
Pennsylvania	724	30.3	19.2	13.5	17.2	19.5	15.2	13.6
Rhode Island	90	14.3	12.9	5.6	6.7	9.3	9.5	4.5
South Carolina	178	26.4	17.2	19.8	29.6	32.7	24.8	17.1
South Dakota	111	27.1	26.7	26.8	32.1	21.6	12.8	21.7
Tennessee	332	28.2	20.2	20.7	21.8	22.9	17.3	12.5
Texas	1,175	29.7	30.5	22.4	18.0	12.0	16.2	18.3
Utah	93	19.5	14.1	25.6	19.0	11.1	8.4	17.9
Vermont	41	22.5	18.2	15.0	10.0	19.5	23.7	13.5
Virginia	281	19.2	14.3	11.6	13.7	10.2	15.5	15.8
Washington	247	46.9	38.3	37.0	30.9	28.1	27.2	24.1
West Virginia	132	12.1	17.7	20.4	12.7	9.8	15.0	9.7
Wisconsin	403	15.8	15.6	11.2	10.9	13.1	18.2	23.0
Wyoming	39	52.8	32.4	25.0	22.9	17.1	11.8	16.2
Nation	**16,172**	**28.4**	**23.3**	**20.2**	**17.8**	**15.7**	**16.8**	**18.9**

Source: GAO analysis of OSCAR and PDQ data.

Related GAO Products

Nursing Homes: Efforts to Strengthen Federal Enforcement Have Not Deterred Some Homes from Repeatedly Harming Residents. GAO-07-241. Washington, D.C.: March 26, 2007.

Nursing Homes: Despite Increased Oversight, Challenges Remain in Ensuring High-Quality Care and Resident Safety. GAO-06-117. Washington, D.C.: December 28, 2005.

Nursing Home Deaths: Arkansas Coroner Referrals Confirm Weaknesses in State and Federal Oversight of Quality of Care. GAO-05-78. Washington, D.C.: November 12, 2004.

Nursing Home Fire Safety: Recent Fires Highlight Weaknesses in Federal Standards and Oversight. GAO-04-660. Washington D.C.: July 16, 2004.

Nursing Home Quality: Prevalence of Serious Problems, While Declining, Reinforces Importance of Enhanced Oversight. GAO-03-561. Washington, D.C.: July 15, 2003.

Nursing Homes: Public Reporting of Quality Indicators Has Merit, but National Implementation Is Premature. GAO-03-187. Washington, D.C.: October 31, 2002.

Nursing Homes: Quality of Care More Related to Staffing than Spending. GAO-02-431R. Washington, D.C.: June 13, 2002.

Nursing Homes: More Can Be Done to Protect Residents from Abuse. GAO-02-312. Washington, D.C.: March 1, 2002.

Nursing Homes: Federal Efforts to Monitor Resident Assessment Data Should Complement State Activities. GAO-02-279. Washington, D.C.: February 15, 2002.

Nursing Homes: Sustained Efforts Are Essential to Realize Potential of the Quality Initiatives. GAO/HEHS-00-197. Washington, D.C.: September 28, 2000.

Nursing Home Care: Enhanced HCFA Oversight of State Programs Would Better Ensure Quality. GAO/HEHS-00-6. Washington, D.C.: November 4, 1999.

Nursing Home Oversight: Industry Examples Do Not Demonstrate That Regulatory Actions Were Unreasonable. GAO/HEHS-99-154R. Washington, D.C.: August 13, 1999.

Nursing Homes: Proposal to Enhance Oversight of Poorly Performing Homes Has Merit. GAO/HEHS-99-157. Washington, D.C.: June 30, 1999.

Nursing Homes: Complaint Investigation Processes Often Inadequate to Protect Residents. GAO/HEHS-99-80. Washington, D.C.: March 22, 1999.

Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards. GAO/HEHS-99-46. Washington, D.C.: March 18, 1999.

California Nursing Homes: Care Problems Persist Despite Federal and State Oversight. GAO/HEHS-98-202. Washington, D.C.: July 27, 1998.

The CHAIRMAN. Thank you. That is a very fine statement.
Dr. Farris.

STATEMENT OF DR. JAMES RANDOLPH FARRIS, M.D., REGIONAL ADMINISTRATOR, DALLAS OFFICE, CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS), DALLAS, TX

Dr. FARRIS. Good morning, Mr. Chairman. I would like to thank you and the committee for inviting me to discuss the quality of care provided by nursing homes across our Nation upon the 20th anniversary of the Omnibus Budget Reconciliation Act of 1987.

This sweeping legislation ushered in a series of landmark nursing home reform initiatives designed to significantly improve quality of care.

More than 3 million elderly and disabled Americans will receive care in nearly 16,000 Medicare and Medicaid certified nursing homes this year. About 1.5 million Americans reside in these nursing homes on any given day.

Our Nation is aging. It is a reality that shapes the public discourse, looms large in our imaginations, and affects our everyday lives.

As families struggle to care for aging parents and other relatives who are living longer but often with coexisting and chronic health conditions and increasingly complex medical needs, and as more members of the baby-boom generation age into seniority, the need for high-quality nursing home care will grow exponentially.

We have come a long way since OBRA. Nursing home quality, safety, oversight and enforcement have advanced significantly since the reforms were implemented in 1990.

Today, we face a changed and, in fact, much improved landscape that is vastly different from the one that existed even 10 years ago. To that end, CMS is grateful for the support and assistance of current and past members of the Senate Special Committee on Aging who have demonstrated their tireless commitment to these issues.

My statement before you now, as well as my written testimony, will describe some of our most significant and successful initiatives.

At the outset, however, I must express my deep concern for the future of CMS's nursing home survey, certification and quality improvement efforts. Without appropriate funding and adequate resources, the agency will not be able to sustain, let alone strengthen and expand, the programs and initiatives that have yielded positive results thus far.

The high priority that CMS has afforded to meeting and exceeding its statutory requirements in these areas has indeed paid off. 99.9 percent of all Medicare and Medicaid certified nursing homes are surveyed every 15 months or less.

In the coming years, however, to our regret, we may need to shift our limited resources and rethink our priorities. The Medicare budget for survey and certification has remained flat for the last 3 years. Should this trend persist, we anticipate a $25 million shortfall by the middle of fiscal year 2008.

Under such a scenario, it is inevitable that our efforts will sputter and slow. Already, our implementation of systems improvements has wound down to a crawl.

Finally, we face the possibility of less frequent surveys of facilities, diluted oversight of accreditation and compromised progress on the critical front of quality measures, in particular the rollout of a key national demonstration project.

For several years now, improving the safety and quality of nursing home care has been the focus of much Congressional and regulatory attention. For CMS and its partners, it has meant massive effort and unprecedented activity.

Currently, CMS is evaluating the complexity of its immediate sanctions policy in an effort to strengthen it and make it more effective, preparing to issue a civil money penalty analytic tool to help States to monitor enforcement actions and to improve national consistency, planning to seek legislative authority to collect civil money penalties during appeals, planning to analyze the feasibility and costs of systems modifications to improve the interface between complaint and enforcement data systems, and continuing to respond to nursing home complaints in a timely manner.

Nearly 12,000 more complaint investigations were conducted by the agency and the States in 2005 than in 1999. Additionally, since 1990, CMS has been posting nursing home characteristics, survey results and information about facility-specific complaint investigations on its publicly searchable Nursing Home Compare Web site.

For the past few years, nursing homes with the worst quality-of-care track records, dubbed "special focus facilities," have been subject to more frequent surveys and decisive punitive actions if significant improvements are not achieved and sustained. As a result, many nursing homes have been induced to operate within Federal requirements. Clearly, such a program requires considerable resources.

In 2005, the last time Congress increased the Medicare budget for survey and certification, CMS expanded the number of special focus facilities by 35 percent. To the extent that Congress supports the President's 2008 proposed budget for survey and certification, CMS will embark on a highly recommended special focus facility program expansion.

Mr. Chairman, thank you for the opportunity to testify on the quality of care in our Nation's nursing homes. With our combined efforts, continued vigilance and adequate resources, I am confident that we will see continued improvement on this front.

I look forward to answering your questions.

[The prepared statement of Dr. Farris follows:]

STATEMENT OF

JAMES RANDOLPH FARRIS, MD

DALLAS REGIONAL ADMINISTRATOR

CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

THE 20th ANNIVERSARY OF OBRA '87: NURSING HOME QUALITY, STAFFING & ENFORCEMENT ISSUES

BEFORE THE SENATE SPECIAL COMMITTEE ON AGING

May 2, 2007

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Testimony of
James Randolph Farris, MD
Administrator, Dallas Regional Office
Centers for Medicare & Medicaid Services
Before the
Senate Special Committee on Aging
on
The 20th Anniversary of OBRA '87:
Nursing Home Quality, Staffing and Enforcement Issues
May 2, 2007

Chairman Kohl, Senator Smith and distinguished Members of the Committee, thank you for inviting me to discuss the quality of care provided by nursing homes across our nation upon the 20th anniversary of the Omnibus Budget Reconciliation Act (OBRA) of 1987. This sweeping legislation ushered in a series of landmark nursing home reform initiatives designed to significantly improve quality of care, a high priority for the Administration, the Department of Health and Human Services, and the Centers for Medicare & Medicaid Services (CMS). In 2007, about 3 million elderly and disabled Americans will receive care in nearly 16,000 Medicare- and Medicaid-certified nursing homes. About 1.4 million Americans reside in the nation's 16,000 nursing homes on any given day. And, more than 3 million Americans rely on services provided by a nursing home at some point during the year.

Our nation is aging. This reality shapes the public discourse, looms large in our public imagination, and affects our everyday lives—as families struggle to care for aging parents and other relatives who are living longer, but often with co-existing and chronic health conditions and increasingly complex medical needs. As increasing numbers of our nation's baby boom generation retire, the need for high-quality nursing home care will grow precipitously. According to the National Health Statistics Group in the CMS Office of the Actuary, State and Federal governments paid roughly 62.3 percent of total nursing home care costs in calendar year (CY) 2005, the latest period for which complete data are available. Among the larger nursing

home companies, Medicare beneficiaries typically account for 14 percent of a given facility's population, while Medicaid beneficiaries typically account for 65 percent of residents. CMS is committed to working with its sister agencies, other departments and Congress to ensure that America's elderly and disabled receive the high quality care they need and deserve.

Today, twenty years after OBRA '87, I would like to briefly review where we have been on the nursing home quality front; to describe in greater detail how we have progressed since the reforms' 1990 implementation – especially in terms of reporting, oversight and enforcement – and finally, to highlight our plan of action for 2007 and beyond.

QUALITY AND SAFETY COMPLIANCE UNDER OBRA '87

Improving the safety and quality of nursing home care has been the focus of considerable legislative and regulatory attention. Titles XVIII and XIX of the Social Security Act established minimum statutory requirements with regard to resident health and safety, which all nursing homes participating in Medicare and Medicaid, respectively, must meet. In OBRA '87, Congress articulated additional requirements to protect residents against problems like preventable pressure sores, weight loss and accidents. To help ensure compliance with these new federal requirements, OBRA '87 required Congress to issue a range of sanctions for underperforming nursing homes. These included *civil money penalties* (CMPs) and *denials of payment for new admissions* (DPNAs), which accounted for 80 percent of federal sanctions between fiscal years 2000 and 2005. Other sanctions short of termination – for example, directed plans of correction or in-service training, state monitoring and temporary management – can provide incentives for maintaining compliance, impact a facility's revenues, and even compel closure.

More than 4,000 Federal and state surveyors conduct routine inspections of nursing homes to assess whether they are consistently meeting federal quality and safety requirements. By law, these 'standard surveys' occur no less than once every 15 months, and on average, every twelve months. Complaint investigations, conversely, focus on specific allegations regarding resident care or safety and may stem from complaints lodged by residents, family members, or nursing

home employees. Deficiencies are defined as the gap between the nursing home requirements and a nursing home's actual practice. They are categorized according to severity – from minimal harm to immediate jeopardy – and scope – from isolated to widespread. When state surveyors identify deficiencies, facilities are required to prepare a plan of action to correct the problem or problems. State surveyors document how effectively facilities follow-through with their plan of correction through review of acceptable evidence or an on-site visit. Nursing homes are considered 'noncompliant' until they either achieve substantial compliance by correcting the deficiencies or are terminated from Medicare and Medicaid participation.

Since 1998, CMS has been posting the survey results for standard surveys as well as complaint investigations for individual nursing homes, on its publicly searchable *Nursing Home Compare* website. In addition, *Nursing Home Compare* offers pertinent information on facility characteristics to help consumers make informed decisions. State survey agencies enter the relevant information into CMS' Online Survey, Certification, and Reporting (OSCAR) database and provide updates, as appropriate. The data on the Web site pertaining to quality measures originate from clinical data submitted electronically by the individual nursing homes as part of the Minimum Data Set (MDS). The MDS is collected at regular intervals for every resident in a Medicare- or Medicaid-certified nursing home and addresses factors like residents' health, physical functioning, mental status and general well-being. Regulations require that an MDS assessment be performed at admission, quarterly, annually and whenever the resident experiences a significant change in status. While every attempt is made to assure the accuracy and timeliness of the posted information, the Agency advises consumers to supplement the data with information from the ombudsman's office, state agencies, and other public sources.

To address underperformance among individual nursing homes, CMS may level a CMP or DPNA. Agency regulations specify two types of civil money penalties. A per-day CMP can range from $50 to $10,000, depending on whether a case is of the 'non-immediate jeopardy' or 'immediate jeopardy' variety. A per-instance CMP can range from $1,000 to $10,000 per episode of non-compliance. Denials of payment for new admissions (DPNAs) make up a substantial number of federal remedies. CMS is permitted by statute to deny payment for existing nursing home residents, as well; however, this type of payment denial is far less

common. CMS regulations require that nursing homes be notified at least 15 days in advance of the imposition of all sanctions, except CMPs. The requirement for advance notice is shortened to two days in cases where deficiencies have been judged to pose immediate jeopardy to the health and safety of residents. If a nursing home can correct the cited deficiencies during the advance-notice period, a DPNA is not imposed. If the facility chooses to appeal the imposition of a DPNA, denial of payment is *not* deferred until such appeals are resolved. CMS is also authorized to impose discretionary DPNAs and terminations in situations not explicitly cited, so long as facilities are given the appropriate notice.

CMS takes four factors into account when imposing sanctions on a nursing home: (1) the scope and severity of the deficiency, (2) prior compliance history, (3) desired corrective action and long-term compliance, and (4) the number and severity of deficiencies overall. In general, the severity of the sanction increases with the severity of the deficiency. For example, in cases of 'immediate jeopardy,' temporary management, termination or both are required and CMPs permitted. For deficiencies falling in the middle of CMS' scope and severity scale – at the level of 'actual harm' – temporary management, a DPNA, a CMP, or a combination thereof, is required. DPNAs are imposed when nursing homes fail to comply with program participation regulations within three months of the noncompliance finding. Termination from the program is the result when nursing homes fail to achieve compliance within six months of the noncompliance finding. Significantly, the statute stipulates that CMS act on deficiencies in a way that minimizes the time between identification and imposition of the sanctions.

Finally, the Federal government and the states share responsibility for enforcement of nursing home quality-of-care requirements. In general, sanctions are initially proposed by state surveyors based on cited deficiencies; then reviewed, imposed, and ultimately put into effect by CMS regional offices.

CMS INITIATIVES TO ENSURE NURSING HOME QUALITY

The most effective approach to ensuring quality is one that mobilizes all available tools and

aligns them in a comprehensive strategy. CMS' action plan for 2007 and beyond consists of five inter-related and coordinated approaches:

Consumer Awareness and Assistance—The elderly, disabled and their friends and families must be active, informed participants in ensuring the quality of their care in any healthcare system. The availability of relevant, timely information is critical because it sets the stage for holding the healthcare system accountable for the quality of services it provides. To that end, CMS is committed to continually updating and expanding the resources and information provided on www.Medicare.gov and *Nursing Home Compare*. The Agency is exploring options for the refinement of a nurse-staffing quality measure to better account for case-mix and risk-adjustment. Currently, each nursing home is required to report its nursing staff hours to the state survey agency. CMS uses the data to report total nursing staff hours *per resident, per day*; drilling down further to identify per-resident, per-day staff hours by Registered Nurse (RN), Licensed Practical and Vocational Nurse (LPN/LVN) and Certified Nursing Assistant (CNA). While instructive, these figures do not *necessarily* reflect the number of nursing staff present at any given time or the amount of care given to any one resident. While at present, there is no Federal standard for specific levels of nurse staffing in a nursing home, CMS requires nursing homes to employ sufficient staff to adequately care for all residents.

Survey, Standards, and Enforcement Processes—This year, CMS is rolling out numerous initiatives to improve the effectiveness of surveys and the management and follow-through of complaint investigations. Since problems may occur between routine surveys, complaint investigations allow surveyors and CMS to assess whether nursing homes are consistently promoting and protecting the health, safety, and welfare of residents. CMS continues to require that State survey agencies use a national, electronic tracking system that monitors the processing and investigation of complaints from intake to resolution. Outcome data is now available across provider and supplier types. CMS prioritizes the concerns of nursing home residents and family members, and is committed to responding to them in a timely manner. Nearly 12,000 more complaint investigations were conducted by the Agency and the States in 2005 than were conducted in 1999.

For the last few years, nursing homes with the worst quality-of-care track records – dubbed 'Special Focus Facilities' (SFFs) – have been subject to more frequent surveys and decisive punitive action if significant improvements are not achieved and sustained. As a result of this program, many nursing homes have been induced to operate within federal requirements. . In 2005 CMS expanded the number of 'Special Focus Facilities' by 35 percent. The President's proposed budget for survey and certification in 2008 will enable CMS to explore expanding the program as it applies to nursing homes and improving on the quality care they offer the nation's most vulnerable populations.

CMS has also taken great care in updating its interpretive guidance for nursing home surveyors, focusing first on requirements that relate to quality of care and quality of life. This updated guidance supports a nationally consistent application of the survey process in evaluating facilities for compliance with nursing home requirements, based on current standards of practice and investigative protocols.

Lastly, CMS continues to make improvements to its survey process. Since the inception of OBRA'87 there have been several improvements, including using national quality data in focusing on quality problems. CMS is in the midst of a pilot of the QIS survey process – a computer assisted survey system that shows promise in increasing consistency and more objective documentation. However, expansion of this survey process will largely rely on increased resources to implement this program nationally.

Quality Improvement—CMS continues to zero-in on reducing the use of restraints and the incidence of pressure sores, which compromise the health and well-being of a significant number of nursing home residents. The Agency also acknowledges the current 'culture change' movement and echoes OBRA principles of knowing and respecting each nursing home resident to better provide individualized care and enhance quality of life. The concept of 'culture change' encourages facilities to change outdated practices, allows residents more input in and control over their own care, and encourages staff to be more responsive to individual resident needs. Further, by requiring nursing homes to offer residents influenza and pneumococcal vaccine, the Agency is helping to ensure the health of residents while setting the stage to report facility-level

immunization rates and immunization measures for compliance and quality comparison.

Quality Through Partnerships—CMS' Quality Improvement Organizations (QIOs), state survey agencies, non-governmental organizations and others are committed to strengthening their partnership and continuing to coordinate their education and enforcement activities to achieve lasting improvements in nursing home care. CMS is part of a national nursing home quality campaign – Advancing Excellence in America's Nursing Homes. This campaign brings together 18 national organizations representing consumers, nurse clinicians, medical directors, provider organizations, unions, foundations, and Quality Improvement Organizations. Nursing homes, consumers, and organizations can sign up to work on eight goals ranging from reducing pressure sores to reducing unnecessary restraints. To date nearly 3,500 nursing homes have signed up. Also, this year, CMS will translate national goals regarding restraint use and pressure sore incidence into their regional equivalents; improve its follow-up with States, and analyze the relevant data to generate state- and facility-specific rates.

CONCLUSION

Mr. Chairman, thank you for the opportunity to testify on the quality of care in our nation's nursing homes. With our combined efforts and continued vigilance, I am confident we will continue to see improvements on this critical front. I look forward to answering your questions.

The CHAIRMAN. Thank you, Dr. Farris.

Ms. Allen, your March report suggests that penalties applied by CMS against the worst-performing homes appear to be ineffective, since many of these homes continue to cycle in and out of compliance.

Why do you think that the penalties are ineffective? How much of this problem occurs at the State level, and how much of it is attributable to CMS?

Ms. ALLEN. It begins at the State level. It is up to the State to decide to what extent that they will use their own authority. States do have their own authority to impose penalties, and some choose to do that. Then, they can decide if they want to refer to CMS to impose penalties. Some choose to do that. Then, CMS makes the decision to what extent that it will provide notice, and then there is an opportunity for appeals.

With civil monetary penalties, as I said earlier, while it is under appeal, they do not have to pay it. So there is a combination of factors that depend on the timeliness and the effectiveness of it.

One of the reasons that CMS advised us that they tend to go with the lower end of the range is because they are concerned that, by taking resources away from the home, that that will interfere with their ability to provide the care that needs to be. So they see that that could be really counter to the intent for putting money toward direct care.

The CHAIRMAN. Are these penalties that are meted out almost always appealed?

Ms. ALLEN. They are often appealed, yes.

The CHAIRMAN. That takes time?

Ms. ALLEN. Yes, it does. That was one of the recommendations, though, that we made in our report, and CMS agreed that it would seek the authority that it needs to try to have the penalty paid up front when it is imposed. Then, if it is overturned at a later time, that it is refunded or something, with perhaps even interest. There is precedent for that in other Federal programs.

The CHAIRMAN. Would that be a significant improvement, or cause, in your opinion, a significant improvement in these homes that are being sanctioned, if they were required to pay the penalty up front pending the appeal?

Ms. ALLEN. We think it could be more of a deterrent effect, yes.

The CHAIRMAN. What about you, Dr. Farris? Do you think that would help?

Dr. FARRIS. I think it would. As my colleague has said, we are certainly pursuing establishment of escrow accounts that will allow us to be able to collect those penalties in advance, up front, and be able to refund them if necessary. But because of the fact that the appellate process does take a while, it would send a strong message if we were able to make these collections early on.

The CHAIRMAN. Ms. Allen, your testimony cites concerns that CMS's double-G immediate sanctions policy, in which homes cited for actual harm in successive inspections are immediately notified by CMS that a sanction will be implemented, is not working as intended.

Should CMS consider scrapping the 15-day notification interval during which homes can correct the deficiencies and escape the proposed penalty? What else might we do?

Ms. ALLEN. We did not recommend that they scrap the 15-day notice, because the home deserves to have notice. But what we do recommend is that CMS simplify the policy, because the immediate sanctions policy is a complicated policy. It is even very complicated to explain about with all the requirements and how it works.

Again, we made some recommendations to CMS about how it could simplify it and remove some of the barriers that get in the way of even imposing the penalties. Again, CMS has agreed that the complexity has been a hindrance to its implementation, and they are working to do that.

The CHAIRMAN. Dr. Farris, you want to comment on that?

Dr. FARRIS. Yes. We agree on those comments. It is important for us to take a look at the reasons why some homes do conform, some homes do correct the deficiencies that they have, and some homes don't.

Certainly, we agree that there is some complexity to the double-G policy, and we are re-evaluating that policy. We are going to look at it and see if it would make sense to significantly change it.

The period of time that facilities have for their notice is a required period of time, so we really can't scrap that. But we can look at ways that we can more efficiently and more effectively give them notification that they are out of compliance and that we do plan to impose penalties.

We certainly are looking at revamping that policy and simplifying it to make it more workable and more effective.

The CHAIRMAN. How important is it, in your opinions, that we really do come up with a system that more effectively does sanction those facilities successfully that are not in compliance and require them to get in compliance or go out of business?

Is this something that you would say is a really, really high priority in this industry, that we do a much better job of ferreting out those institutions that are not providing the kind of quality care? That we have a system to not only identify them, but insist that there be quick compliance or that they be fined or even put out of business?

What is your sense of priority on this, Ms. Allen?

Ms. ALLEN. GAO would suggest that there needs to be some mechanism to deal with the homes that repeatedly are out of compliance on a continuous basis. We had multiple examples of that in our most recent report that was just released.

When so many Federal dollars are going into these homes and there are vulnerable residents who are experiencing significant neglect from the care, it is difficult to explain how those homes can be allowed to continue to participate in the Federal programs.

Now, as CMS responded in its comments to our report, and we would agree, that sometimes it takes a combination of factors. Sometimes it is not sanctions alone, monetary sanctions, because, again, that could be taking money out of the system.

But there are other ways. There is denial of payment for new admissions. There are temporary managers that can go in. Perhaps if the home is a member of a chain, there can be ways to have the

chains hold them accountable for bringing in additional resources. There can be alternatives.

One of the concerns about terminating a home is, that what happens with the residents? There is the concern about transfer trauma. Where do the residents go? That is a difficult issue.

But at the same time, which is worse: staying in a home where a person is receiving very poor and negligent care, or moving to a facility where they may receive better care? It is a very difficult dilemma.

But again, it seems like that, for the homes that are providing very poor care on a continuous basis, there really is a question whether they should be allowed to continue in the Federal program.

The CHAIRMAN. Thank you.

Dr. Farris, what are your thoughts?

Dr. FARRIS. We think that there is definitely a great need to prioritize, making certain that homes that do participate in the Medicare and Medicaid programs provide good-quality care. There are a number of mechanisms that can be implemented to ensure this short of termination.

I think Ms. Allen is entirely correct in mentioning entities such as transfer trauma. We know that transfer trauma is a real problem for some residents of long-term care facilities, particularly those who are cognitively impaired.

We also know that, in the part of the world where I live, there are access problems. There are times when closing a facility may mean that the next closest facility is anywhere from 60 to 200 miles away. This imposes a hardship on families who would like to go and visit their relatives.

So we are looking, No. 1, as I said earlier, to try to find a way to find out why some homes will improve and implement sustainable corrections and why others will not.

The special focus facilities that I mentioned earlier would be one example. We started out in 1999 with 100 of those facilities. We expanded it in 2005 to 135. We are looking very closely at what we can do to improve the quality of care in these facilities, which are considered the worst of the worst.

There are a number of different modalities that are available, as I said and as Ms. Allen mentioned, in addition to the civil monetary penalties we have, denial of payment for new admissions, but we also have the ability to go in and provide them with directed plans of care and directed plans of correction.

We are also looking not to penalize the residents of these homes, who are really helpless in this situation and very vulnerable. So we are looking at ways that we can work with the boards of directors of these homes, and particularly in cases where they are parts of national chains. We want to make certain that, if the owners are not the operators, we make the owners aware of the fact that poor care is being rendered in these facilities.

So we are applying a multi-pronged approach to try to bring these facilities along, and we are studying what works and what does not over the course of time. I think that we will be able to come up with some measures and some mechanisms that will allow

us to ensure high-quality care and terminate only when it is absolutely necessary.

The CHAIRMAN. This is, I think fairly obviously, but I think we need to highlight it and discuss it a bit. We are talking about, in every case almost, management, right? It is people who are in charge of the facility or their immediate bosses.

I have found, in my experience, where you have good management, inevitably you have a well-operated business, whether it be nursing homes or anything else. Where you have poor managers, that is where you run into trouble.

Isn't it true, or is it not true, that in these problem facilities, if you could replace management with a different management, you would almost be certain to expect improvement? Would you make that judgment?

Ms. Allen.

Ms. ALLEN. It is management. It is leadership. It is also resources. It is a matter of the resources that are going into the home, in terms of nursing level, the nurse aid level, as well as nutrition and a number of things. So it is not only the leadership, but it is also the financial resources, as well.

The CHAIRMAN. I am sure that is true.

Dr. Farris.

Dr. FARRIS. Ms. Allen is absolutely right. It is multi-factorial. We think that the resource constraints that some facilities have would need to be addressed in order to allow them to provide better care, working with the leadership, and again, particularly if the ownership is different from the management of the facilities.

It is important to make sure that that board of directors that is in charge, or the owners of the facilities, are made aware of the fact that there are problems there that need to be addressed. In some instances, perhaps in many instances, those boards or that leadership can actually bring to bear some of the other parameters that will allow us to make corrections, such as infusing more resources into it.

The CHAIRMAN. We have, what, about 16,000 nursing homes across the country, and the estimate is that perhaps 20 percent are on that list of having to need great improvement, so that is like 3,000.

Is that somewhere in the ballpark, without trying to be too arithmatic? Because obviously even the other 80 percent, many of those can improve. But in terms of really needing direct attention, would you say that there may be 20 percent out of the 16,000 that you might estimate that would be on that list?

Ms. Allen.

Ms. ALLEN. Yes, that is correct. But may I just add a comment to that, or another perspective?

One of the things that I mentioned in my remarks is that there is great variation across the States with that number. It ranges from about 2 percent in one State that reports on nursing homes that are cited for actual deficiencies to a high of almost 50 percent of homes in another State.

We don't believe that the actual quality really varies that much. What we believe, rather, is that it shows differences in terms of

how quality is assessed. That is one of the reasons—and at the same time, we also have found that there is understatement.

So there could be understatement across the States across the board. So we continue to be concerned about what the data are telling us.

That is one of the reasons, though, that we would like to suggest it is so important that some of the measures that CMS is working on, for example its survey methodology, is so very important, because we need to know what is going on in the homes. There needs to be more consistency in terms of how the level of care and quality of care is being assessed.

So I just wanted to make that remark. We are confident that about 20 percent of the homes are being cited for deficiency of care, but it does vary across the States very significantly. We need to pay attention to that variation, as well.

The CHAIRMAN. That is a good comment.

Dr. Farris.

Dr. FARRIS. I think that that variation is key to this discussion. We are working with State survey agencies. We have begun to implement training for the State survey agencies to make certain that we take out any differential that may be there on a State-by-State basis to make sure that the protocols are implemented consistently across the country.

In terms of the numbers of facilities, again, as we said, we have already identified 135 of the worst of the worst facilities. Certainly we think that that number could be expanded. I wouldn't go so far as to say it could be expanded to 20 percent based upon the variation and the variability that we just talked about, but it can certainly be expanded beyond 135.

To the extent that the resources are infused into the survey and certification budget, we can expand that number, just as we did in 2005 where we increased it by 35 percent, to be able to look at a larger number of the worst of the worst and to begin to work with them to bring them into compliance.

The CHAIRMAN. Would you say that, if you had sufficient resources, an increase in the resources that you have now, that you could make a quick and significant improvement in these troubled homes?

Dr. FARRIS. We can certainly begin to effectuate improvements and to find ways to not only implement these improvements but to also ensure that they are sustainable, to work with these homes on an ongoing basis and to work with our State survey agencies, again, to achieve consistency.

But also to work with the homes through the various modalities that we talked about, applying not only sanctions but also management, different management to come in, and directed plans of care, to ensure that they do come into compliance and continue or begin to provide good quality of care on a sustainable basis.

The CHAIRMAN. Ms. Allen, is it a question of resources?

Ms. ALLEN. I think that there is no doubt that additional resources would be helpful.

The CHAIRMAN. OK.

We have with us the very fine Senator from Missouri, Claire McCaskill.

Would you make some comments, ask some questions?

Senator MCCASKILL. Thank you, Mr. Chairman.

One of the issues I think, having done a number of audits on nursing home care as the State auditor in Missouri, and looking at what I think those of us who have spent some time on this issue call the roller-coaster syndrome, that is the right-to-cure problem.

There is this incredible tension between the inspectors on the ground in terms of keeping that facility open and penalizing appropriately to mandate that the care improves.

Reality: You have a small nursing home in a small community, and they are getting cited and curing, getting cited and curing, and, frankly, were it not for the reality of where would those people go, I think they might be tougher and, frankly, appropriately tougher on some of the nursing homes.

But I think what happens to the inspectors on the ground that are doing the surveys is, one, they develop relationships with the administrators. They see some administrators that are trying to do good but are having difficulty, whether it is—I know we are going to talk about the nursing shortage, but there is a real shortage in terms of qualified health care professionals, especially at the level of pay that some of these nursing homes can give.

I guess, has there been any efforts to look at having a mandatory plan in place in every State that would allow for the transferal of patients on an immediate basis so that tension is relieved?

In other words, having so many beds being required to be available in facilities that haven't had Class I violations, that haven't had the history of problems, and that—because I think if you really began to have some dramatic penalties, like, "Hey, you are done, we are shutting the door," I think you would have more of a deterrent effect on some of the other consistently problematic homes.

Have there been any States that you are aware of that have always had kind of a plan in place to transfer nursing home residents, long-term care residents, to other facilities?

Ms. ALLEN. GAO has not specifically looked at that systematically.

We do know that one of the more effective penalties has been denial of payment for new admissions. In other words, if there are problems, to simply say we are not going to allow any more to come in until you correct that. In other words, if there is something to affect the income stream, that can be a powerful incentive to correct.

One of the other issues, though, in some respects, the occupancy rate of nursing homes has been coming down. So in some communities, it may be possible to transfer residents to another nearby facility. There may be other beds. If there are Medicaid beds available—and that is typically the population we are talking about, Medicaid beds—there may not be a Medicaid-certified bed available, so that is an issue of availability.

There may also be, though, the issue of, in the smaller community, more rural community, is there an available facility for them to go to? That is one of the very difficult issues. Are there alternatives for that?

There is the issue of transfer trauma that is a very difficult issue as well. So we acknowledge it is a very difficult issue about what

do we do at that point where there is a tradeoff between poor care being delivered, particularly for those that is chronically poor care, cycling in and out of compliance, the roller-coaster effect.

If you care about the resident, which is better or worse: moving the resident someplace else out of that facility, which is more compassionate, or to leave them in that facility, where they may continue to get——

Senator MCCASKILL. Less-than-great care.

Ms. ALLEN. Less-than-quality care.

Dr. FARRIS. Well, Senator, you raise a very important point that actually revolves around the issue of access. As we begin to look at imposing sanctions against a nursing home, and particularly if we are considering strongly the termination of the provider agreement for that nursing home, we begin to work in conjunction with the State to find places where there is adequate capacity for patients to be moved.

Aside from the conversation about the transfer trauma, which is a real entity, we have found that there are circumstances in which it is very difficult to move patients from one facility to another.

In some instances it will be imposed by geographic constraints. There may not be another home within 60 to 100 miles, where a number of patients could be transferred, and this imposes a hardship on the families that would want to visit those patients.

We also have to look at special needs that some patients may have. Some facilities have a particular expertise in taking care of certain types of patients. One of the ones that we recently dealt with had to do with ventilator patients. There is not a lot of capacity if you need to move patients from a home where there are ventilator-dependent patients. There are some homes that have large populations of pediatric patients, which require some special care, and you cannot put those into every particular situation.

So access becomes very important as we start to look at where we can move people. We always work with the States to allow them to tell us where that capacity is, or if it is not there.

So, yes, you are absolutely right. There are instances in which we are not able to move forward with termination because of access issues or because of real strong concerns about transfer trauma.

But there are other modalities that we can implement, short of termination, such as bringing in new managers, different managers, imposing directed plans of care, that we will force them to implement. These modalities have been shown to actually bring them back into compliance.

But as we have said, one of the things that we are looking for is to find sustainable corrections.

Senator MCCASKILL. Right.

I have so many areas I would like to cover in this because of the work that we did on this in Missouri. But one of the things that is troubling me about the future of nursing home care is that there is a trend in my State to begin to use nursing homes as an alternative to mental health facilities by public administrators.

In the urban areas of our State, there are mental health facilities that the courts can use to place people that they believe must be put in a facility. But as you probably are aware, in our country, we began trying to de-institutionalize our mental health patients by

moving them "out into the community." Well, in some instances, that meant to a homeless shelter. In rural areas, where you don't have any kind of safety net for the homeless population, many times they end up in a probate court as a ward of the court, and the court determines they must be placed somewhere.

Well, if you are in a relatively rural area, where are you going to place these people that may be schizophrenic or psychopaths? Well, they are being placed in nursing homes.

So you have two types of populations in the same nursing home. You have an elderly geriatric population that, frankly, with what is changing in our health care spectrum, where we are going all the way from assisted living, home health care, and we have the wide spectrum that we didn't have—people's notion that people are going into nursing homes to play checkers and maybe stay a while and go back home, that is not what the reality is in nursing homes now in terms of acuity.

We have a much larger population. It is non-ambulatory. You have people that have much more aggressive needs in terms of day-to-day care because they are only there because the hospital is not letting them stay in the hospital anymore, and they are going there to die because they can't be cared for in their home with hospice, or whatever. Many of them are.

Then, you have the juxtaposition of a mental health population under the same roof, with two separate requirements in terms of regulation. You may have a probate judge telling that nursing home, "You must keep this population from wandering anywhere. They must be in lockdown." Then, you have the requirement for the nursing home population that you put them in the least restrictive environment, that you can't use restraints or you are not allowed to use restraints because that, in fact, would be sanctioned if you were inappropriately using restraints on the geriatric population. Well, then inspectors come in to do surveys, and they see a mental health patient that is being used with restraints, and they are getting cited.

So, what steps has CMS taken to acknowledge these two different types of population?

If it is happening in my State, I am sure it is happening in other States, this juxtaposition between—and kind of the gray area in the middle is the Alzheimer's. What is happening is a lot of these mental health patients are ending up in Alzheimer's units. So, that is completely inappropriate.

By the way, a lot of these staff don't have a requirement to even train their people on the mental health issues, how to deal with the mental health population. So you have people who have been trained to deal with somebody who is non-ambulatory and geriatric that is now dealing with a sociopath or a schizophrenic. It is just not good.

I am curious what, if anything, is going on in your agency to acknowledge that this is happening in our country, and taking steps to make sure that we have the appropriate regulations, inspections and training in place.

Dr. FARRIS. Yes, Senator. You, again, raise a very important point. This has been recognized, and it is something that is being addressed by the leadership at CMS.

The long-term care team that has been put together across the agency, across CMS, where we have input from a number of different sources, is taking this sort of situation under advisement. It has been recognized.

If I may change hats for just one second and go back to my former life as a public health official, the de-institutionalizing of the mentally ill that took place back in the 1980's has really caused a number of problems not only in this particular setting, but——

Senator MCCASKILL. Don't even get me started on the group homes that have nobody doing surveys. I mean, there are no surveys going on in these mental health group homes.

What is going on in terms of abusive practices and wrong medication, the top of my head can blow off if I start thinking about what is going on to these poor people in some of these group homes across our country.

Dr. FARRIS. Let me just say that, during the time that I was the Dallas County health director in Texas, the largest mental health institution in Dallas was the Dallas County Jail.

Senator MCCASKILL. Right.

Dr. FARRIS. Until we are able to address the appropriate placement of patients with mental illnesses, actually through the system of jurisprudence, we tried to implement a system where there were diversion programs to keep people out of the criminal justice system who had mental illnesses.

I think we need to begin to look at this problem from the same perspective as it relates to nursing home patients, because many of the patients who go into the nursing homes are not going because they want to; they are being sent there. So it has to be addressed at a different level.

Senator MCCASKILL. I am worried about the families of the elderly. I mean, what I worry about is we are not doing full disclosure. If you are about to place a loved one in a nursing home, do we have an obligation to tell them that they have a half a dozen sociopaths that have been committed to that facility?

We are talking about young people. We are talking about people, many of whom have tendencies to act out, sexually and aggressively, and in terms of assaultive behavior, and they are being heavily medicated in order to deal with that.

Do we have an obligation to make sure that consumers that are going to use a nursing home are aware that there are these people in the nursing home? Do we need specific regulations requiring that nursing homes that have these dual populations, that there is two standards of training and that States should have two sets of regs, making sure that there is the appropriate oversight in both areas?

Dr. FARRIS. Well, Senator, I think as the group that I mentioned, our long-term care team at CMS, begins to delve more deeply into these issues, we will be more than happy to get back with you to let you know where our thinking is going on this and how we plan to address this issue.

Senator MCCASKILL. I would appreciate that, because, at the same time, we do have a problem of census in terms of these homes. So homes are looking at ways to fill the beds, so they are

turning to this issue. Now, some are doing it responsibly, with training. Some of them aren't.

I think getting a handle on this is really important because, as these nursing homes deal with struggling census—and census is the bottom-line determinator as to whether or not they can afford to pay the people who work there to give the care that is necessary.

I don't want to shut off the availability of bed space to mentally ill people who need it, and it may be that we need to take a role as government in designating facilities as those that are appropriate to receive these types of patients when we are confident that we have the appropriate amount of training and oversight in place.

Dr. FARRIS. We will be very happy to get back with you on that.

Senator MCCASKILL. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Senator McCaskill. Those were really insightful comments based on your experience and questions, and made a real contribution.

We thank you both for being here this morning. You have been excellent witnesses, and I think you have shed a lot of light on this issue. Thank you so much.

Dr. FARRIS. Thank you.

The CHAIRMAN. Our first witness on our second panel will be Charlene Harrington, who is a professor of sociology and nursing at the University of California in San Francisco. Professor Harrington's research focuses on quality, access, utilization and nursing home expenditures, home and community-based care, as well as personal care services. She has been a leader in nursing home care reform efforts for the past 3 decades. She has served on the Institute of Medicine's panel, whose 1986 report led to the passage of the Nursing Home Reform Act of 1987.

The second witness will be Alice Hedt, executive director of the National Citizens Coalition for Nursing Home Reform, which is an advocacy organization that provides information and leadership and Federal and State regulatory legislative policy development to improve care and life for residents of nursing homes and other long-term care facilities. Ms. Hedt will testify that conditions in many nursing homes are still unacceptable, and provide the Committee with recommendations of creating a stronger enforcement system.

Our third witness will be Mary Ousley. Ms. Ousley is the president of Ousley & Associates, former chair of the American Healthcare Association, which is the largest trade organization representing long-term care. Since 1988, she has acted as an advisor, provider representative on the policy and regulatory development of OBRA 1987, on survey and final certification, as well as on enforcement.

Our last witness will be Orlene Christie, who is director of the Legislative and Statutory Compliance Office for the Michigan Department of Community Health. Ms. Christie will discuss how Michigan has designed and implemented its background check program, which excludes individuals with certain criminal histories and records of abuse from working in nursing homes.

So we welcome you all here.

We would start with your testimony, Ms. Harrington.

STATEMENT OF MS. CHARLENE HARRINGTON, PROFESSOR OF SOCIOLOGY AND NURSING, UNIVERSITY OF CALIFORNIA, SAN FRANCISCO, CA

Ms. HARRINGTON. Thank you, Mr. Chairman.

I first became aware of the serious quality problems in nursing homes in 1976, when I was the director of the California Licensing and Certification Program. At that time, about one-third of California nursing homes were providing substandard care.

Today, over 30 years later and 20 years after the adoption of OBRA 1987, still a very large percent of nursing homes offer poor care, resulting in harm, jeopardy and death to residents. Literally dozens of studies, including those by the GAO and the OIG and researchers, have documented these persistent quality problems.

I am going to argue today that three areas need to be improved in order to ensure high-quality care: first, the enforcement of existing laws; second, adequate nurse staffing levels; and third, financial accountability for government funding.

The GAO should be commended for its new report and its recommendations, which I certainly endorse. CMS should revise its enforcement procedures and practices to streamline them, to increase the size of penalties, and take swift action against poor performing nursing homes.

In addition, our studies of the wide variation in enforcement practices across States have found that the States that do a better job of enforcement are those that receive higher survey and certification funds from CMS. This shows the need for increased Federal funding for State survey agencies.

Moving to the underlying issue of poor quality in nursing homes, I really think there is no mystery about it. The basic problem is that we have inadequate nurse staffing levels in nursing homes.

The positive relationship between high nurse staffing levels, especially R.N. staffing, and the quality of care in nursing homes has been shown in numerous studies. A study by Abt Associates for CMS in 2001 reported that a minimum of 4.1 hours per resident per day, including .75 R.N. hours, are needed to prevent harm to residents with long stays in nursing homes. Two IOM reports have recommended increased minimum Federal staffing standards for nursing homes.

Unfortunately, the total nurse staffing levels across the country have remained flat for the last 10 years, well below the recommended levels, and some nursing homes have dangerously low staffing. Shockingly, R.N. staffing hours have declined by 25 percent across the Nation since the year 2000 alone.

The decline is directly related to the implementation of the Medicare Prospective Payment System, because nursing homes no longer need to provide the level of nursing care that is paid for in the Medicare rate. Recognizing the low staffing, some States have begun to set their own minimum staffing levels, and Florida has recently established a 3.9 total nurse staffing level.

Studies have shown that nursing homes will increase staffing if the Medicaid reimbursement rates are increased. This encourages nursing homes to add more staff. But a new study that I have just done shows that high State minimum licensed staffing standards

are the most effective policy that you can use to get the staffing levels up.

The nursing turnover rates continue to be high, and those reduce the continuity and the quality of care, and they increase the cost of nursing homes. Turnover rates are directly related to the heavy workloads that nurses have and the low wages and benefits and poor working conditions.

Now, government is paying 61 percent of the Nation's nursing home expenditures, so it has focused most of its efforts on cost containment. The majority of State Medicaid programs have adopted prospective payment systems, and nursing homes respond by cutting their staff and cutting their quality to stay under those rates.

In 1998, when Medicare adopted prospective payment, it was established, but with very little or no accountability. One way to make nursing homes more financially accountable under prospective payment is to establish cost centers.

Four cost centers should be set up: one for direct care, like nursing and therapy; one for indirect care, like housekeeping and dietary; three, for capital costs; and four, for administrative costs.

After the rates are determined for each cost center, the nursing home should be prevented from shifting funds away from the nursing and the direct care to pay for administrative costs for capital or profits. Retrospective audits should be conducted to collect funds that were not expended on the direct and indirect care that it was allocated for, and penalties should be issued for diverting funds away from direct care.

In summary, we need to improve the enforcement, the staffing levels and the financial accountability if we are ever going to solve these intractable quality problems.

Thank you very much.

[The prepared statement of Ms. Harrington follows:]

UCSF
University of California
San Francisco

May 2, 2007

Proposals for Improvements in Nursing Home Quality

Testimony Prepared by Charlene Harrington, Ph.D., RN., Professor, School of Nursing, University of California San Francisco, and Associate Director, UCSF John A. Hartford Center for Geriatric Nursing Excellence, and Director of the Nursing Health Policy Doctoral Program

The quality of nursing homes continues to be a major problem in the US. I first became aware of the serious quality problems in 1976 when I was the Director of the California Licensing and Certification program. At that time, the program determined that about one-third of California nursing homes were providing substandard care. Today, over thirty-years later, California and the rest of the nation continue to have many nursing homes that offer substandard care resulting in harm, jeopardy, and even death to residents every year.

Literally dozens of studies by researchers, the US Government Accountability Office, the US Inspector General for Health and Human Services, and others have documented the persistent quality problems in a sizable subset of the nation's nursing homes since the US Senate Committee on Aging first began holding hearings on nursing homes.[1-4]. Even though some nursing homes offer high quality of care, the persistent quality problems continue to shock and dismay us.

I am going to argue that three areas need to be improved to ensure high quality nursing home care. These are: (1) the enforcement of existing laws, (2) adequate nurse staffing levels in nursing homes; and (3) financial accountability for government funding of nursing homes.

ENFORCEMENT

The most recent GAO (2007) report found that the number of serious deficiencies and sanctions declined in four states between 2000 and 2005 and that this decline is related to weaknesses in the survey system and the use of sanctions.[5] Often quality problems are not detected

and when they are, the scope and severity of problems are underrated. Nursing homes with serious quality problems continued to cycle in and out of compliance, causing harm to residents. The report recommended similar findings to previous GAO reports[2-4] in that CMS should: (1) improve the immediate sanctions policy, (2) strengthen the deterrent effect of certain sanctions, (3) expand the enhanced enforcement for homes with a history of noncompliance, and (4) improve the effectiveness of the agency data reporting systems on enforcement.

Failure to Improve Quality and Enforcement Since the 1970s. The new GAO report is very similar to reports identified by the Institute of Medicine (IOM) Committee on Improving the Quality of Nursing Home Care in 1986.[6] As a member of the IOM committee that issued the 1986 report on widespread quality problems in nursing homes, we recommended stronger enforcement federal regulations by using intermediate sanctions of civil money penalties, holds on admissions, and temporary management/receiverships to force poor nursing homes to come into compliance.[6] These recommendations were adopted by Congress in passing a major reform of nursing facility regulation in the Omnibus Budget Reconciliation Act of 1987 (OBRA, 1987).[7] OBRA (1987) required changes to strengthen the quality standards, the survey process, and the enforcement mechanisms for nursing facility regulation. OBRA (1987) and its subsequent regulations also mandated uniform comprehensive assessments for all nursing home residents and required the survey process to focus on resident outcomes.

Declining Sanctions Imposed Since 2000. Unfortunately, the bureaucratic nursing home enforcement procedures and the poor survey process overseen by the Centers for Medicare and Medicaid Services result in few deficiencies being issued (7.1 per facility in 2005) and a decline in deficiencies issued for harm of jeopardy (from 30.6 in 1999 to 16.9 in 2005).[8] Moreover, few civil money penalties (CMPs), holds on admission, and temporary management/receiverships, are issued for serious violations of federal regulations.[9-12] In 2004, 41 states collected 3,057 CMPs worth $21

million, but CMPs were given for only two percent of deficiencies issued.[12] As the new GAO report pointed out, few nursing homes are decertified from the Medicare and Medicaid programs or closed.[5]

State Survey Agency Problems. The weak survey process is related to a number of factors including poorly trained surveyors, shortages of survey staff, high survey agency staff turnover related to poor salaries, the lack of timely surveys, the lack of timely complaint investigations, the predictability of surveys, and other problems.[3-5] These problems are sometimes compounded by the negative attitudes of federal and state survey officials to enforcement activities.[11,12] Some state officials have reported that they are opposed to federal enforcement actions and they either do not implement the federal requirements (like CMPs) or only implement sanctions for the worse facilities.[11,13] Others report federal officials sometimes overrule state sanction recommendations which also results in weak enforcement.[11]

Interviews with state survey agency officials have identified their strong frustration with the CMS regulatory process. Some states described the federal enforcement system as an administrative nightmare and most prefer their own state procedures for CMPs.[11,13] One state (Maryland) issues and collects state CMPs fines immediately and puts the fines in a special account until the final adjudication process is complete in order to make the penalties more timely.[12] This approach could be taken by CMS. Most states (73 percent) reported inadequate federal funds to carry out their regulatory activities, while about half reported inadequate state funds for regulatory activities.[11,13]

CMS should revise its enforcement procedures and practices to increase the size of the penalties and to take swift action against poor performing nursing homes. Those nursing homes with repeated serious violations should be forced out of business using receiverships and temporary management procedures so that new high-quality owners can be found without having to close

nursing homes. Implementation of the recommendations by the GAO (2007)[5] is of critical importance.

State Enforcement Variation. Our studies have examined the wide variations in enforcement procedures across the US. Studies have found that states that taken more enforcement actions and issue more CMPs are those that have higher state survey agency budgets from CMS.[12,14] State survey agencies with more staff and resources to implement the federal requirements can be more effective with the enforcement process, which can be time consuming and expensive. We conclude that the state variations in enforcement practices could be addressed in part by increased funding for state survey agencies, at the same time that other improvements are made in the enforcement policies.

STAFFING ISSUES

Relationship of Nurse Staffing and Quality

Nursing home quality rests entirely in the hands of nurses, nursing assistants, and other providers who deliver formal care and assistance. Nursing homes are labor intensive and require nursing staff that are well educated, with experience and compassion. The processes of care include assistance with activities of daily living (such as bathing and dressing) and special nursing services such as wound care, nutrition and incontinence management, medication and behavioral management, chronic disease management, and other complex care processes.

The positive relationship between nurse staffing and quality of care in nursing homes has been shown in a number of studies reported by the Institute of Medicine.[15-16] Higher staffing hours per resident, particularly Registered Nursing (RN) hours, have been consistently and significantly associated with overall quality of care including: improved resident survival rates, functional status, and incontinence care; fewer pressure sores and infections; less physical restraint, catheter and antibiotic use; less weight loss and dehydration; less electrolyte imbalance; improved nutritional

status; lower hospitalization rates, improved activity participation rates, and a higher likelihood of discharge to home.[15-19] Better staffing is associated with lower worker injury rates and less litigation actions. Studies have also found that gerontological nurse specialists and geriatric nurse practitioners contribute to improved quality outcomes in nursing homes and lower risk-adjusted hospitalization rates.

Safe Staffing Levels

A study by Abt Associates for CMS (2001) reported that a minimum of 4.1 hours per resident day were needed to prevent harm to residents with long stays (90 days or more) in nursing homes.[17] Of this total, .75 RN hours per resident day, .55 LVN hours per resident day, and 2.8 NA hours per resident day were reported to be needed to protect residents.[17] The report was clear that residents in homes without adequate nurse staffing levels faced substantial harm and jeopardy. In order to meet the total 4.1 hours per resident day, 97% of homes would need to add some additional nursing staff.[17] A study of nursing homes in California also confirmed the threshold for nurse staffing hours needed to ensure high quality; the study found no differences in measurable outcomes until staffing was at 4.1 hours per resident day or higher.[18] Nursing homes with high staffing (4.1 hours per resident day or higher) performed significantly better on 12 of 16 care processes (such as feeding assistance) compared to lower staffed homes.[18]

Two IOM reports have recommended increased federal minimum staffing standards for nursing homes because the federal standards are so low (one RN on duty 8 hours a day for seven days a week and a licensed practical nurse on duty on evenings and nights per nursing home).[15,16] In 2003, an IOM committee report on Keeping Patients Safe recommended that CMS adopt the minimum staffing levels from the Abt study for all nursing homes in the US, along with 24 hour RN coverage.[16,17] The IOM report identified the strong relationship between higher resident casemix

(acuity) and the need for higher nurse staffing levels and greater nursing expertise when residents have higher acuity.

Nursing Home Staffing Levels

In spite of recent efforts to increase nurse staffing levels in nursing homes, the total average staffing has remained flat, at 3.6 to 3.7 hours per resident day (hprd) rsince 1997, and well below the recommended levels.[8] Staffing levels vary widely across nursing homes, and some homes have dangerously low staffing levels.[8]

The shocking situation is that the RN staffing hours per patient in US nursing homes have declined by 25 percent since 2000.[8] The decline in staffing levels is directly related to the implementation of the Medicare prospective payment system (PPS) for skilled nursing homes and this in turn has led to a reduction in nursing home quality outcomes.[20,21] Under PPS, Medicare rates are based on each facility's resident needs for nursing and therapy services but skilled nursing homes do not need to provide the level of care that is paid for by the Medicare rates. The declining RN levels in nursing homes and quality of care shows the need for regulatory standards and incentives to improve staffing levels.

Minimum Federal Staffing Standards. Unfortunately, the Centers for Medicare and Medicaid Services has not agreed to establish minimum federal staffing standards that would ensure that nursing homes meet the 4.1 hours per resident day (hprd), mostly because of the potential costs.[17] Considering that most nursing homes are for-profit and have significantly lower staffing and poorer quality of care,[22,23] these facilities are unlikely to voluntarily meet a reasonable level of staffing. If staffing levels are to improve, minimum federal staffing standards are needed along with additional funding.

State Standards. Many states have begun to raise their minimum staffing levels since 1999 (e.g. California (3.2 hprd) and Delaware (3.29 hprd)).[24] Recently, Florida established a 3.9 hprd

total licensed and licensed minimum standard. Except for Florida, most of these new standards are improvements, but they are still well below the 4.1 hprd level recommended by the CMS 2001 report.[17] When standards are established, states need to monitor the standards. After five years, 22 percent of California nursing homes still do not meet the state's 3.2 hrpd minimum standard in 2005.[25] Efforts to improve the minimum staffing standards that are case mix adjusted should continue to have the highest priority at the state and federal levels.

State Minimum Licensed Staffing Standards. Studies have shown that increasing state Medicaid reimbursement rates is one approach to improve staffing levels in nursing homes.[26] A new study also shows that higher Medicaid nursing home reimbursement rates are related to higher RN and total nursing hours per resident, but state minimum licensed staffing standards are a stronger predictor of higher RN and total nursing hours.[27] To increase staffing levels, average Medicaid reimbursement rates would need to be substantially increased, while increasing the state minimum RN staffing standards would have a stronger positive effect on RN and total nursing hours.[27]

Staff Turnover Rates. Nursing home turnover rates range from 50 to 75 percent of staff leaving employment each year, showing that retention is major problem.[17] High turnover rates reduce the continuity and stability of care, lead to miscommunications, and result in patient safety problems as well as worker injuries and poor morale. High nursing turnover has been found to be related to decreases in nursing home quality.[28] Moreover, turnover of nursing aides is estimated to cost billions per year in the US. Turnover is directly related to heavy workloads (inadequate staffing levels), low wages and benefits, and poor working conditions.[16, 17, 28, 29] The goal should be to stabilize the LTC workforce by investing in the workers in increased wages and benefits.

Accurate and Timely Staff Reporting Requirements. The current CMS reporting system, which requires nursing homes to report on two weeks of nurse staffing at the time of the

annual survey, is inadequate and sometimes inaccurate.[17] These reports are not audited and are collected during annual state surveys when nursing homes often increase their staffing. Complete daily reporting for all types of staff and for total staff from payroll records should be required of nursing homes on a quarterly basis, using a standard reporting format that requires nursing homes to certify the accuracy of their reports.

Consumer Report Cards on Staffing. One important strategy for improving quality of care is to provide consumers with information about quality of care as a means for making more informed decisions about health care. Public reporting and ratings of nursing homes based on key indicators including nurse staffing levels as well as turnover, wages, and benefits are strongly recommended. One model for such a report card was developed by the University of California and the California Health Care Foundation (www.calnhs.org).

Payment Incentive Systems. As interest has grown in payment incentive systems, it is important to consider what indicators of quality are the most appropriate to consider. At this point, staffing levels, turnover rates, wages, and benefits are all concrete measures that are directly related to quality. These indicators can be accurately and reliably measured. As noted above, these indicators are more directly related to care than many clinical measures (such as pain) which are sometimes inaccurately measured and reported, are difficult to risk adjust, and can be easily gamed by providers.[18] If we want to give human resources top priority, incentives that encourage more staff, better education and training, and workforce stability should be considered.

Staff Screening and Training. Another approach to improving quality is to have criminal background checks for all nursing home employees. A number of states require criminal background checks but there is no federal requirement. The federal government should make this a minimum requirement for working in nursing homes. The training of nursing home assistants has

also been weak with only 75 hours required by the federal government.[15,16] This amount of training should be doubled or tripled to improve the quality of care.

FINANCIAL ACCOUNTABILITY

Nursing home reimbursement methods and per diem reimbursement rates are of great importance because they influence the costs and quality of care. Medicaid and other public programs paid for 47 percent of the nation's total $115 billion nursing home expenditures, while Medicare paid for 14 percent, with the remainder paid by consumers, private insurance, and other payers in 2004.[30] Because of its high proportion of total nursing home expenditures, government reimbursement policies have primarily focused on cost containment rather than quality of care. Government's cost containment goals often conflict with quality goals.

Medicaid Rates. Medicaid reimbursement rates in states are substantially lower than other payers. Medicaid nursing home payments were an average of $115 per day across the nation, while Medicare rates for freestanding nursing homes were $269 in 2000.[31,32] Medicaid rates fell short of costs by $9.78 per day in 2000.[31] Low Medicaid reimbursement rates can result in nursing homes discriminating against Medicaid residents and in poor quality of care for facilities with high percentages of Medicaid residents.[33,34] An increase in Medicaid reimbursement rates improved quality as measured by an increase in the use of RN staff and reduced deficiencies in the tightest regional markets.[26] Nursing homes are not likely to increase staffing without adequate Medicaid reimbursement rates.

Prospective Reimbursement Rates to Control Costs. The majority of states have adopted Medicaid prospective payment systems (PPS) for nursing homes and Medicare adopted PPS in 1998. PPS sets rates in advance of payments, based on past allowable costs, whereas a retrospective payment system is one in which payment is based on actual past costs. PPS methodologies are successful in controlling reimbursement growth rates[35] but nursing homes tend to

respond by cutting the staffing and may reduce the proportions of debilitated patients nursing homes will accept.[35] PPS can have negative effects on quality of care unless accountability is ensured.

Medicare Prospective Payment Systems (PPS). Congress passed prospective payment system (PPS) reimbursement for implementation starting in 1998 to reduce overall payment rates to skilled nursing homes.[31,32] Following provider pleas to Congress, additional Medicare payments improved the revenues for many nursing homes. In spite of the reimbursement changes, excess profits have grown. A GAO study of Medicare profit margins found that the median margins for freestanding SNFs were 8.4 percent in 1999 and increased to 18.9 percent in 2000.[32] The 10 largest for-profit chains had margins of 18.2 percent in 1999 and 25.2 percent in 2000.[32] Medicare PPS does not limit the profit margins that nursing homes can make.

Medicare developed a complex and elaborate system for establishing its PPS nursing home payment rates, but little financial accountability. As noted above, under Medicare PPS, nursing homes do not need to ensure that the amount of staff and therapy time is equal to the amount that is allocated under the Medicare rates. Nursing homes may spend the funds they receive without being required to spend the funds on direct care. This is also the case in many states under Medicaid payment rules. As noted above, after the adoption of Medicare PPS, RN staffing levels declined by 25 percent and poor quality of nursing home care increased.[21,22]

Cost Centers. One approach to make nursing homes more financially accountable under Medicare and Medicaid PPS systems is to establish cost centers. Four general cost centers could be established: (1) direct care services (e.g. nursing, activities, therapy services), indirect care (including housekeeping, dietary, and other services), capital costs (e.g. building and land costs), and administrative costs. Medicaid and Medicare should determine prospectively the amount of funds allocated for each of these costs centers. Nursing homes should then be prevented from shifting funds across cost centers. This would require nursing homes to target funds for direct care

(nursing and other direct care providers) and for indirect expenditures to those services. Funds should not be diverted from direct and indirect services to pay for administrative costs, capital costs, and profits. Moreover, nursing homes should have to report nursing hours separately on the Medicare cost reports.

To ensure that the reimbursement rates are used for the intended purposes, retrospective audits should be conducted to collect Medicare and Medicaid funds not expended on direct and indirect care. Penalties should be issued for diverting funds from direct and indirect services.

Summary

In summary, the most important measure of quality of care is the amount of nursing staff available to provide care. In nursing homes, the decline in registered nurses and the failure to improve staffing shows the need for greater regulatory standards and incentive systems. Turnover rates, wages, and benefits must be improved to address nursing home quality. Greater financial accountability is needed to ensure that Medicare and Medicaid funds are spent on direct and indirect care and not diverted to paying for real estate, administration, and profits. We must invest in our long term care workforce so that high quality providers will be available to provide care for our family members, friends and ourselves when we need such care.

References

1. US Senate Special Committee on Aging. 1973-74. Special Hearings on Nursing Homes. Washington, DC: US Senate.
2. U.S. General Accounting Office (GAO). 1987. Report to the Chairman, Subcommittee on Health and Long-Term Care, Select Committee on Aging, House of Representatives. *Medicare and Medicaid: Stronger Enforcement of Nursing Home Requirements Needed.* Washington, DC: U.S. GAO.
3. U.S. General Accounting Office. 2000. *Nursing Homes: Sustained Efforts Are Essential to Realize Potential of the Quality Initiatives-- Report to the Special Committee on Aging, U.S. Senate. GAO/HEHS-00-197.* Washington, DC: General Accounting Office.
4. U.S. General Accounting Office. 2003. *Nursing Homes Quality: Prevalence of Serious Problems, While Declining, Reinforces Importance of Enhanced Oversight--Report to Congressional Requesters GAO-03-561.* Washington, D.C.: General Accounting Office.

5. U.S. Government Accountability Office. 2007. *Nursing Homes: Efforts to Strengthen Federal Enforcement Have Not Deterred Some Homes from Repeatedly Harming Residents.* GAO-07-241. Washington, D.C.: GAO.
6. Institute of Medicine (IOM), Staff and National Research Council Staff. 1986. *Improving the Quality of Care in Nursing Homes.* Washington, DC, National Academy Press.
7. Omnibus Budget Reconciliation Act of 1987 (OBRA) (1987). Public Law 100-203. Subtitle C: Nursing Home Reform. Signed by President, Washington, D.C., December 22.
8. Harrington, C., Carrillo, H., and LaCava, C. 2006. *Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1999-05.* San Francisco, CA: University of California. **www.nccnhr.org.**
9. Harrington, C. and Carrillo, H. 1999. The Regulation and Enforcement of Federal Nursing Home Standards. *Medical Care Research and Review.* 56 (4):471-494.
10. Hawes, C. 2002. *Assuring Quality in Nursing Homes: The Role of Enforcement. Final Report for the Retirement Research Foundation. (RRF 99-209).* College Station, TX: The School of Rural Public Health, Texas A&M System Health Science Center, April.
11. Harrington, C.. Mullan, J.T. & Carrillo, H. 2004. State Nursing Home Enforcement Systems. *Journal of Health Politics, Policy and Law.* 29, 43-73.
12. Tsoukalas, T., Rudder, C., Mollot, R.J., Shineman, M., Lee, H.Y. and Harrington, C. 2006. The Collection and Use of Funds From Civil Money Penalties and Fines from Nursing Homes. The Gerontologist. 46 (6):759-771.
13. Harrington, C., Tsoukalas, T., Rudder, C., Mollot, R.J., and Carrillo, C. 2007. Variations in the Use of Civil Money Penalties for Nursing Homes. San Francisco, CA: University of California.
14. Walshe, K. & Harrington, C. 2002. The Regulation of Nursing Facilities in the US: An Analysis of the Resources and Performance of State Survey Agencies. *The Gerontologist,* 42, 475-486.
15. Institute of Medicine (IOM), Wunderlich, G.S. and Kohler, P., Eds. 2001. *Improving the Quality of Long-Term Care.* Washington, DC: National Academy of Sciences, IOM.
16. Institute of Medicine. 2003. *Keeping Patients Safe: Transforming the Work Environment of Nurses.* Washington, DC: National Academy Press.
17. US Centers for Medicare and Medicaid Services, Prepared by Abt Associates Inc. *2001. Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes. Report to Congress: Phase II Final.* Volumes I-III. Baltimore, MD: CMS.
18. Schnelle, J.F., Simmons S.F., Harrington, C., Cadogan, M., Garcia, E., and Bates-Jensen, B. 2004. Relationship of Nursing Home Staffing to Quality of Care? *Health Services Research.* 39 (2):225-250.
19. Castle, N.G. and Engberg, J. 2007. The Influence of Staffing Characteristics on Quality of Care in Nursing Homes. *Health Services Research.* In Press.
20. Konetzka, R.T., Yi, D., Norton, E.C., and Kilpatrick, K.E. 2004. Effects of Medicare Payment Changes on Nursing Home Staffing and Deficiencies. *Health Services Research.* 39 (3):463-487.
21. Konetzka, R.T., Norton, E.C., Sloane, P.D., Kilpatrick, K.E. and Stearns, S.C. 2006. Medicare prospective Payment and Quality of Care for Long-stay Nursing Facility Residents. *Medical Care.* 44 (3):270-6.
22. Harrington, C., Woolhandler, S., Mullan, J., Carrillo, H., & Himmelstein, D. 2001. Does Investor-Ownership of Nursing Homes Compromise the Quality of Care? *American Journal of Public Health.* 91, 1452-1455.

23. O'Neill, C., Harrington, C., Kitchener, M., & Saliba, D. 2003. Quality of Care in Nursing Homes: An Analysis of the Relationships Among Profit, Quality, and Ownership. *Medical Care*, 41, 1318-1330.
24. Harrington, C. 2005. Nurse Staffing Standards in Nursing Homes in the United States: Part I. *J. of Gerontological Nursing.* 31 (2):18-23.
25. Harrington, C. and O'Meara, J. 2007. Snapshot: The Changing Face of California's Nursing Home Industry. Oakland, CA: California HealthCare Foundation. http://www.chcf.org/documents/hospitals/ChangingFaceNursingHome07.pdf
26. Grabowski, D.C. 2001. Does an Increase in the Medicaid Reimbursement Rate Improve Nursing Home Quality? *Journal of Gerontology: Social Sciences.* 56B (2):S84-S93.
27. Harrington, C., Swan, J.H., and Carrillo, H. 2007. Nurse Staffing Levels and Medicaid Reimbursement Rates in Nursing Facilities. *Health Services Research.* 42 (3): In Press.
28. Castle, N.G. and Engberg, J. 2005. Staff Turnover and Quality of Care In Nursing Homes. *Medical Care.* 43 (6):616-26.
29. Harrington, C. and Swan, J.H. 2003. Nurse Home Staffing, Turnover, and Casemix. *Medical Care Research and Review.* 60 (2):366-392.
30. Smith, C., Cowan, C., Heffler, S., Catlin, A., and the National Health Accounts Team. 2006. National Health Spending in 2004: Recent Slowdown Led By Prescription Drug Spending. *Health Affairs.* 25 (1):186-196.
31. US Centers for Medicare and Medicaid Services, Scully, T. 2003. *Health Care Industry Market Update. Nursing Facilities.* Washington, DC: CMS, May 20.
32. U.S. General Accounting Office. 2000. *Nursing Homes: Aggregate Medicare Payments Are Adequate Despite Bankruptcies.* Testimony Before the Special Committee on Aging, U.S. Senate. GAO/T-HEHS-00-192. Washington, DC: U.S. General Accounting Office, September 5.
33. Harrington Meyer, M. 2001. Medicaid Reimbursement Rates and Access to Nursing Homes: Implications for Gender, Race, and Marital Status. *Research on Aging.* 23/5: 532-551.
34. Mor, V., Zinn, J., Angelelli, J., Teno, J.M. and Miller, S.C. 2004. Driven to Tiers: Socioeconomic and Racial Disparities in the Quality of Nursing Home Care. *Milbank Quarterly.* 82 (2): 227-56.
35. Cohen, J.W. and L.C. Dubay. 1990. The Effects of Medicaid Reimbursement Method and Ownership on Nursing Home Costs, Case Mix and Staffing. *Inquiry.* 27:183-200.

The CHAIRMAN. Thank you for your very fine statement.
Ms. Hedt.

STATEMENT OF MS. ALICE H. HEDT, EXECUTIVE DIRECTOR, NATIONAL CITIZENS' COALITION FOR NURSING HOME REFORM, WASHINGTON, DC

Ms. HEDT. Good morning.

Twenty years ago I was a local ombudsman in North Carolina, working with 12,000 residents in eight counties. I joined the Coalition for Nursing Home Reform because that organization was leading the way to get OBRA written and implemented. I am honored to be here to represent that organization today.

Senator Kohl, we particularly want to thank you for your leadership on criminal background checks, on funding on the ombudsman program, and on the Elder Justice Act.

I also want to point out that your homestate, Wisconsin, has one of the best procedures for nursing home closures, so that residents do not suffer from transfer trauma like they do in some of the other States. It should be held up as a model for the rest of the Country.

The CHAIRMAN. Thank you.

Ms. HEDT. When OBRA was passed in 1987, a lot of changes started happening in nursing homes that I was able to observe.

Those changes included taking off of restraints of residents. At that time, over 40 percent of residents were restrained. If you think about it a minute, if those numbers were realized today, it would mean that 680,000 people each year would be restrained in nursing homes. Right now, our rate is about 10 percent. We need to make a lot of improvements in that, but there has been a significant change.

Residents also were chemically restrained, and one resident, Judith Mangum, who has been on our board of directors and been in a nursing home since before OBRA, told me that she went into the nursing home and was literally drugged because she was 21 years old and they didn't know what to do with her. We have seen significant changes in that area.

Social workers at that time became very involved in promoting residents' rights, and so did long-term care ombudsmen. One of those particularly that is still with us is from Missouri, Carol Scott, the State ombudsman. They worked hard to make sure that residents knew that they don't give up their Constitutional rights as United States citizens just because they enter a facility.

Mail started being delivered every day. People started knocking on doors before they went into residents' rooms. There were huge improvements.

I was proud to be a part of an organization that led a coalition to bring about nursing home reform, and that included many people in the room today—consumers, providers, health professionals.

Sadly, our vision for nursing home reform was not realized, and has not been realized over the last 20 years. I want to point to four major reasons why.

The first, as Ms. Harrington discussed, is staffing. We know, that there has to be a minimum standard of 4.1 hours of nursing care per resident each day to have adequate care, so that residents are not harmed. Ninety percent of facilities do not staff at this stand-

ard. Moreover, consumers do not know at what levels facilities are staffing because there is not accurate, audited, publicly available data on nursing home staffing at this time. NCCNHR has a staffing standard that details the staff needed for quality care. NCCNHR has a staffing standard that details the staff needed for quality care.

Particularly important is the role of nurses. We know that pressure sores, weight loss and other serious problems that residents can experience can be directly impacted by having more R.N. care.

A lot of times, we forget that there are high costs to poor care. When we don't have enough staff, it results in high cost and increased hospitalizations, more pressure sores and other things that are very costly to us as a society.

The second big area is the enforcement of OBRA that needs to be addressed. We fully support the GAO recommendations that were brought forth today.

From a consumer viewpoint, we feel strongly that information about sanctions needs to be made available to the public. Right now, if I choose a nursing home, I can't tell if that nursing home has been sanctioned or not. I don't know if admissions have been closed. This information needs to be on Nursing Home Care. Consumers have a right to know which nursing homes the states and CMS have sanctioned.

We also feel that temporary managers should be used, and the good-performing facilities should be able to take over poor-performing facilities so that it is not the residents that suffer.

Residents and their family members also need to be involved in dispute resolution. Right now, it is the facilities that have the option of disputing the survey's findings, not the complainant or the resident.

I want to put into the record our "Faces of Neglect" book. This documents family members who suffer terribly in nursing homes, and whose facilities, in most cases, were not sanctioned. The system literally broke down for these families. We need to make sure that other Americans do not suffer like these families did.

Third, I want to point out that facilities themselves can make a huge difference in implementing OBRA. OBRA called for individualized resident care. If care is individualized, that will handle the issues around people with mental illness, because facilities should have staff that are trained and equipped to handle those facilities. If care is individualized, that should handle the issues of people with very specific needs going into facilities and with dementia that need to be handled.

Besides staffing and enforcement, we want to make sure that every nursing home in the country uses total quality management practices to work for individualized care. The Pioneer Movement can assist in this, the Quality Improvement Organizations (QIOs), the Advancing Excellence Campaign, are all resources that facilities can use to improve management and move toward individualized care.

Finally, consumers are asking that information be made publicly available that they need. Consumers need to know about the staffing levels. They need to know about if a facility has been sanctioned. They need to know, and want to know, about the cost re-

ports and how tax dollars are being used in facilities. Basically, they need to know who owns and manages facilities. Right now, that information is not available to the public on nursing home compare.

Today, 20 years after the implementation of OBRA, a lot of us that worked on that issue will soon need long-term care, as will our family members. So I thank you for holding this hearing and not forgetting the 3 million Americans who need and utilize nursing home care now and those of us who will need care in the future.

Thank you.

[The prepared statement of Ms. Hedt follows:]

Statement of Alice H. Hedt

Executive Director
NCCNHR: The National Consumer Voice for
Quality Long-Term Care

"The Nursing Home Reform Act Turns Twenty:
What Has Been Accomplished, and
What Challenges Remain?"

Senate Special Committee on Aging

Senator Herb Kohl, Chairman
May 2, 2007

Good Morning:

I am pleased to be here this morning on behalf of NCCNHR to talk about the Nursing Home Reform Law, OBRA '87, which played a particularly meaningful role in our history as the National Citizens' Coalition for Nursing Home Reform. Before beginning my testimony I would like to thank you, Senator Kohl, for your long-time advocacy for higher funding for the ombudsman program and the survey and certification system. NCCNHR also appreciates and supports your efforts to require criminal background checks on those who work with vulnerable long-term care residents, and your efforts to help pass the Elder Justice Act, the first comprehensive legislation since OBRA '87 to address serious neglect and abuse in long-term care.

Twenty years ago, the Nursing Home Reform Law set forth key principles of quality that had been carefully identified in the 1986 Institute of Medicine Report and established them as minimum standards that were to be the foundation of quality of care and quality of life. These standards are now so much a part of long-term care that we tend to forget how truly reforming the law was and how it continues to set forth requirements that are essential to ensuring dignity for our nation's 1.7 million nursing home residents.

Twenty years ago, I was working as a local ombudsman responsible for 12,000 residents in an eight- county area. I was also a member of NCCNHR, supporting its diligent efforts to bring about much needed reforms through a coalition of consumers, providers, unions, and professional associations who labored together to produce a consensus on nursing home reform legislation. That coalition, the Campaign for Quality Care, continues to meet regularly today to support better care in nursing homes. Now, as the Executive Director of NCCNHR, I want to applaud those Campaign participants who worked tirelessly in 1986 and 1987 to ensure passage of the law.[1] Under the leadership of its Founder, Elma Holder, NCCNHR coordinated this national effort to pass federal legislation that set forth standards that would respect each resident, guaranteeing them the care and quality of life that they needed and deserved. The Campaign's work was transformed into law by the fine members of this committee, including Senators David Pryor, John Heinz, and John Glenn, and by Majority Leader George Mitchell.

In the years following the passage of the NHRL, significant changes began to take place in the facilities I visited and across the country. Residents who had been tied to their chairs and to their beds were untied. At the time OBRA was enacted, more than 40 percent of nursing home residents in this country were physically restrained, a magnitude of misery and bad care that would be

[1] American Association of Homes for the Aging; American Association of Retired Persons; American College of Health Care Administrators; American Federation of State, County, and Municipal Employees; American Health Care Association; American Nurses Association; American Occupational Therapy Association; American Psychological Association; Association of Health Facility Licensure and Certification Directors; Catholic Health Association; D.C. Long-Term Care Ombudsman Program; Gray Panthers; Montgomery County Long Term Care Ombudsman Program; National Association of Social Workers; National Association of State Long-Term Care Ombudsman Programs; National Association of State Units on Aging; National Citizens' Coalition for Nursing Home Reform; National Committee to Preserve Social Security and Medicare; National Council on Aging; National Council of Senior Citizens; National Senior Citizens Law Center; Older Women's League; Service Employees International Union; and Villers Advocacy Associates.

unthinkable in most nursing homes in this country today. As an ombudsman, I finally had federal support to advocate for the tiny, frail woman who would weep every time I visited her, "Set me free, set me free," as she stumbled down the hall with the wooden chair she had been tied to on her back. Equally important, residents who were "zombie-like" due to misuse of medications were given the opportunity to be free from chemical restraints that made it impossible for them to enjoy any type of quality of life.

Social workers across the country began to focus on resident rights education as central to their work in facilities explaining that a person does not give up their constitutional rights as a United States citizen when they enter a facility. Mail began to be delivered daily; residents had control of their personal funds; staff were trained to close curtains for privacy, knock on doors and address each resident by the name that the resident wanted to be called. Resident and family councils emerged as voices for improvement in their facilities. Nursing assistants became certified under the new requirement that they have at least 75 hours of training. (It is hard to believe now that prior to 1987, the typical nurse aide began her career with no formal training at all – "right off the street," as we said then. I will never forget the transformation of a nurse aide who had worked in her facility for over 20 years as she earned her certification for learning new skills and, at last, the right way to perform many of the caregiving tasks she had faithfully executed for so long.)

Residents and family members appreciated finally having the right to see the facility's survey (inspection) report and receive a copy of their rights, including the identity and role of their ombudsman. Most important, and central to the entire law, was that care was to be individualized; facilities were to:

> *Provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of* ***each resident*** *in accordance with a written plan of care.*

For the first time, care was to be based on an individualized care plan that residents and their family members (if the residents wanted them to) were to be involved in developing with the staff who provided the resident's care.

In the midst of these changes, exemplary providers and strong advocates began developing true models of individualized, resident-directed care. Models that reflected that nursing homes were homes where residents were to be respected by listening to them and basing their care, activities and other day-to-day decisions on what they said defined quality for them as an individual. These providers are now a part of the Pioneer Network, a movement birthed at a NCCNHR Annual Meeting by visionary individuals who are leading the industry from an institutional to an individualized system of long-term care. Their work is demonstrating that it is possible to fulfill the law through *culture change* based on the full involvement of facility residents, family members and workers, particularly the nursing assistants who provide 90 percent of resident care.

Sadly, I cannot report to you today that the expectations and requirements of the NHRL have been fulfilled in the 20 years since its passage. In fact, for many residents, the quality of their day-to-day care is minimal because of inadequate nurse staffing. A congressionally authorized study released

by the Department of Health and Human Services in two phases in 2000 and 2001[2] demonstrated what our members have told NCCNHR for more than 30 years – there are insufficient numbers of nurses and nursing assistants in the vast majority of America's nursing homes. Daily calls to NCCNHR from consumers and those who advocate with them reinforce what NCCNHR has long held, that no matter how well-trained staff are, how much technology there is for them to work with, how well supervised they are -- all important factors -- there simply is a limit on how much care a single person can provide. One CNA left a message on NCCNHR's voice mail in the middle of the night, "Can you help me? I care so much about these people but there is only one of me and 24 of them. I am failing them and myself." NCCNHR has actively supported Rep. Henry Waxman's Nursing Home Staffing Act, which would require Medicare and Medicaid facilities to meet the staffing standards identified in the two HHS studies. These reports and other research show that below 4.1 hours of nursing care a day, residents will almost certainly be harmed – suffer from pressure sores, dehydration, malnutrition, fractures, infections, and other conditions that cause pain, decline in functioning, avoidable hospitalizations, and death.

An important dimension of staffing is that residents need more direct care time by registered nurses. A 2005 study demonstrated that increased RN direct care results in fewer pressure ulcers, hospitalizations, and urinary tract infections; less weight loss, catheterization, and deterioration in activities of daily living – all outcomes that residents deserve.[3]

It is important to pass the Waxman bill, and we hope that it will soon be reintroduced in the House and Senate. There are interim steps that can also be taken, however. CMS has been conducting research for almost a decade on how to collect, audit and report accurate nurse staffing data from payroll records and it has an additional contract to develop nurse staffing quality measures. NCCNHR believes it is time for Congress to tell CMS to move forward on collecting accurate information about every Medicare and Medicaid nursing home's staffing levels and provide this information to consumers, policymakers, researchers, and others who need it. Today, neither government agencies nor consumers can say with certainty what the nurse staffing levels are in most of our country's nursing homes.

NCCNHR is a founding member of *Advancing Excellence in America's Nursing Homes*, a campaign that includes many of the same organizations that participated in the Campaign for Quality Care to pass the Nursing Home Reform Law. *Advancing Excellence* is a nationwide campaign among providers, consumers, and those who staff nursing homes to achieve certain voluntary goals, including improving clinical care and addressing workforce issues. NCCNHR is urging every nursing home in the country to participate and to select the workforce goals of reducing turnover and adopting consistent assignment staffing practices that allow nurse aides to work on a daily basis with the same residents, building the personal bonds that improve both the quality of care and the quality of life in the nursing home experience. The standards of the Nursing Home Reform Law cannot be met unless these two workforce measures are addressed by facilities as a part of their quality improvement processes.

---

[2] *Report to Congress. Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes*, Health Care Financing Administration, Summer 2000, and *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Phase II, Final Report*, Centers for Medicare and Medicaid Services, Winter 2001.

[3] "RN Staffing Time and Outcomes of Long-Stay Nursing Home Residents," Susan Horn, et al., American Journal of Nursing, November 2005.

As the Government Accountability Office has reported today in another of its series of devastating reports on weak enforcement of the NHRL, the law is not being fulfilled for far too many residents due to the failures of our enforcement system that is too often provider rather than consumer focused. Residents and families are not allowed the opportunity to be a part of the dispute resolution process, even though the findings are about their complaints and their care in the facility. Our members tell us that facilities do not pay fines that are imposed for many years, and that in many cases, there are no fines imposed even when care has been neglectful and in some cases had horrific results. Residents tell us that they are frightened to raise their concerns because they are vulnerable and dependent, and family members tell us about retaliation, such as restrictions on their right to visit their loved one, when they attempt to get good care. These pervasive consumer problems are too often not addressed by the enforcement system.

Tragically, what residents, their families and advocates tell us substantiates all the reports by the GAO, the Inspector General, and others: Facilities are allowed to continue in "yo-yo" compliance for years, resulting in severe suffering and sometimes death. NCCNHR documented these "Faces of Neglect" in a book in 2006[4] so that policymakers would never forget that the faces of those who bear the brunt of poor care are our mothers, fathers, grandparents, friends – in for-profit and non-profit facilities across the country. It must be remembered that these so-called "poor performing nursing homes" are in reality the homes of our elders, the vulnerable, the medically fragile, and those who are near the end of their lives; and it should be noted that in most of the terrible cases of neglect and abuse that are recorded in this book, there was no penalty for the facility or the staff that caused such great suffering and, in most of the cases, unnecessary death. We are asking that *The Faces of Neglect* be included in the record of this hearing as witnesses to the suffering that our system imposes.

The NCCNHR Board of Directors discussed these issues last weekend and agreed that there is serious and great disparity among the states in terms of the nursing home care being provided -- differences in restraint usage, in how sanctions are utilized (and not utilized) to bring about change, in how facilities are inspected and how complaints are handled. This disparity demonstrates a failure of leadership on the part of CMS to ensure confidence that no matter where our parents receive nursing home care, the care fulfills the requirements of the NHRL. CMS could promote quality throughout the country by promoting consistency in inspections and sanctions; using temporary managers so that it is the management of the facility, not the residents, who have to leave when a facility is closed; and by making sure that all states provide consumers the opportunity that providers have to dispute survey findings.

Those who worked to pass OBRA '87 had a great vision – that the federal government has a legal responsibility to ensure that people who live in nursing homes have quality of care and quality of life. That vision has only been partially utilized, but we have the potential to fully implement this law. Many of those involved in the passage of the law will soon need care themselves. Even though our programs and public policy are moving towards more home and community-based care, there continue to be almost 2 million people in nursing homes in any given year for rehabilitation or for long-term care. More and more of us are spending the last days of our lives in a nursing home rather than in a hospital. Those in facilities today are frailer but as isolated and

[4] *The Faces of Neglect: Behind the Closed Doors of Nursing Homes*, NCCNHR, April 2006.

vulnerable as those who were in nursing homes 20 years ago. Those residents are us – the advocates and providers and Congress people who worked for reform years ago, and who now need the protections and the safeguards of the system for themselves, for their loved ones and for all in our society who need long term care.

NCCNHR urges Congress to:

- Support Rep. Waxman's Nursing Home Staffing Act and policies that provide necessary resources for adequate staffing.
- Require CMS to implement administrative procedures to improve nurse staffing levels, such as citing facilities for staffing violations when deficiencies are related to understaffing.
- Require CMS to implement a system to collect, audit and publicly report nurse staffing data and quality measures based on payroll records.
- Pass Senator Kohl's legislation to require criminal background checks on all staff of long-term care facilities who come into contact with residents.
- Pass legislation to address the GAO's recommendations in the March 2007 report, *Nursing Homes: Efforts to Strengthen Federal Enforcement Have Not Deterred Some Homes from Repeatedly Harming Residents*, and to include new statutory protections for consumers, including protection from retaliation and the right to challenge surveys that do not appropriately address deficiencies experienced by residents.
- Appropriate sufficient funds for the Long-term Care Ombudsman Program to ensure that residents have full access to an ombudsman for complaint resolution and one-on-one consultation.
- Appropriate sufficient funds for nursing home survey and certification to ensure that CMS and state governments are fully staffed and equipped to enforce the law.
- Enact the Elder Justice Act, the most comprehensive long-term care legislation introduced since the Nursing Home Reform Act.
- Investigate ways to hold nursing homes accountable for their expenditure of public funds so that Medicare and Medicaid funds are spent "close to the resident" rather than on administrative costs that benefit the corporation, not the residents.
- Oppose medical malpractice legislation that would deny nursing home residents the opportunity to seek civil justice for neglect and abuse.
- Identify and promote strategies to strengthen the long-term care workforce, including the development of career ladders, mentoring programs, consistent assignment, skilled supervision, and staff involvement in total quality management.
- Promote policies to reduce direct care staff turnover, create a supportive work environment; and ensure adequate living wage compensation, including health care coverage for direct care staff in recognition of the importance of the work they do.
- Identify and promote strategies to implement individualized, resident-directed care in long-term care facilities through culture change.

In closing, NCCNHR would also like to endorse the recommendations of Charlene Harrington.

Thank you again, Mr. Chairman, and members of the Committee for the opportunity to speak for residents, their families, and citizens concerned about nursing home care.

The CHAIRMAN. Thank you very much, Alice.
Mary Ousley.

STATEMENT OF MS. MARY OUSLEY, PRESIDENT, OUSLEY & ASSOCIATES, FORMER CHAIR, AMERICAN HEALTH CARE ASSOCIATION, RICHMOND, KY

Ms. OUSLEY. Thank you. Thank you, Chairman Kohl, Members of the Committee.

Twenty years ago, the passage of the Omnibus Budget Reconciliation Act ushered in an era of change in resident care. Congress made the care mandate very clear: All certified facilities must obtain or maintain the highest practical mental, physical, psychosocial well-being for each resident.

A second mandate of OBRA 1987 was the requirement that each facility establish a quality improvement committee. This important committee offered a platform from which each facility could evaluate their own outcomes of care, as well as the processes that generated good outcomes of care.

This commitment to quality improvement is best demonstrated by a recent quote by acting CMS Administrator Leslie Norwalk. She states, "Nursing home providers have been on the leading edge of this quality movement, long before hospitals, doctors, home health providers, pharmacy, dialysis facilities and others came to the table. The nursing home industry was out front with quality first to volunteer effort to elevate quality and accountability." She goes on to say that quality measurement is working in nursing homes, and it is the best path to high quality.

OBRA 1987 was also intended to move the survey and certification process in a new direction. The statute envisioned a resident-centered, outcome-oriented, consistent system of oversight. Unfortunately, the system that we have today, many times, bears little resemblance to that vision. What we have is a system that defines success and quality in a regulatory context that is often measured by the level of fines levied and the violations tallied, not by the actual quality of care or quality of life.

We, the American Healthcare Association and all of our members, take very seriously the recently released GAO report, and acknowledge that we still have many challenges ahead of us in addressing and improving the Nation's most troubled facilities. However, we are also pleased to note in the report that it indicates that there has been a dramatic decrease in the number of facilities cited for actual harm or immediate jeopardy.

From a historical and comparative standpoint, let us briefly look at the 2003 GAO report, which found an almost 30 percent reduction in the number of actual harm deficiencies cited over an 18-month period. However, it went on to say that it was unclear whether this was due to an understatement of deficiencies or, as we would argue, whether or not it was a true indication of quality improvement.

This dichotomy points to the central problem in understanding today's oversight process and underscores the inability to distinguish the failure to identify deficiencies and true quality improvement.

The GAO makes several recommendations in their report, and I want to highlight and speak to just a few of those.

Recommendations include: Expand the CMS Nursing Home Compare site to include imposed sanctions and homes subject to immediate sanctions, we agree. But we also agree with the concern that the GAO raises in the report that says that if these data are to be put on the Web, then we need to make sure that they are accurate and understandable by families.

No. 2, expand the special focus facility program to include all homes that meet criteria as poor-performing. We support the transparent processes that ensure improvement in these facilities, and encourage greater involvement by the quality improvement organizations in each and every State.

As it has been clearly demonstrated that such cooperation is effective in improving the quality of care, I do want to say we are supportive of CMS terminating consistently poor-performing facilities that cannot achieve or sustain compliance over time.

No. 3, ensure the consistency of the imposition of civil monetary penalties by issuing standardized grids, which was piloted in 2006. We disagree with this recommendation. We believe that circumstances surrounding noncompliance must be evaluated on an individual basis before any remedy can be imposed, and we do not believe a standardized grid would achieve this goal.

We believe the path to continued improvement is found in assessing the effectiveness of the joint Federal provider nursing home quality initiative and our own quality first. I am proud to say it is working, and it is being effective.

Here are some of the facts. Key quality indicators tracked by the initiative over the past 5 years have shown improvement, including improvement in pain management for nursing home residents, reduced use of restraints, decreased number of residents with depression, and decrease in occurrences of pressure ulcers, just to mention a few.

We all know that the satisfaction of residents and families are absolutely paramount in determining the true quality. A recent independent study showed that four out of five residents and families indicated that they were satisfied with their care, and they would actually rate that care as good or excellent.

Each of us here today seek precisely the same objective, which is to work to improve the quality of health care in our Nation and, specifically, long-term care. To this end, we applaud the legislation, the Long-Term Care Quality and Modernization Act, which Senators Smith and Lincoln introduced in the 109th Congress. We hope that such a bill that encourages a culture of cooperation will be reintroduced.

In summary, Mr. Chairman, Members of the Committee, I have been in long-term care for 30 years, and I can say to you that the commitment to quality has never been higher than it is today. From the CEOs of the major corporations to the individuals that own single facilities, it is on everyone's mind. Everyone is working toward it, and we are doing it, and we are getting better every day.

Over 4,000 nursing homes today are participating in the just-announced-in-September, "Advancing Excellence in America's Nursing Homes." From my perspective, I simply want us to all continue

to work together to take the platform that OBRA 1987 gave us and help us get better every single day and keep these systems and methods evolving so that we all get from our nursing homes what we deserve.

Thank you.

[The prepared statement of Ms. Ousley follows:]

ahca
American Health Care Association

Statement of
Mary Ousley

On behalf of the
American Health Care Association
for the
U.S. Senate Special Committee on Aging

"The Nursing Home Reform Act Turns Twenty: What Has Been Accomplished, and What Challenges Remain?"

May 2, 2007

Thank you Chairman Kohl, Ranking Member Smith, and members of the Committee. I am grateful for the opportunity to be with you here today – and to offer our profession's perspective on both the successes and remaining challenges we face in ensuring ready access to quality nursing home care for the frail, elderly, and disabled Americans we serve.

My name is Mary Ousley and I speak today as past Chair of the American Health Care Association (AHCA), which represents some 11,000 providers of long term care that employ more than 1.5 million compassionate, well trained caregivers.

Having been in the care giving profession for three decades—as a registered nurse, a licensed nursing home administrator and a senior executive of a multi-facility corporation – I am intimately familiar with the challenges front line caregivers face. I also have worked formally and informally with the Centers for Medicare & Medicaid Services (CMS) and its predecessor, the Health Care Financing Administration (HCFA), over several decades, in various capacities, and on many issues. My experiences have made me acutely aware that providing quality care for seniors and people with disabilities depends on having a collaborative relationship among providers, government, consumers, and the other long term care stakeholders.

I want to note from the outset that CMS and HCFA have worked long and hard to implement the *Omnibus Budget Reconciliation Act in 1987 (OBRA '87)* which sought to improve patient care in our nation's nursing homes. As well, I am impressed with their willingness to meet with us and listen to our profession's concerns. I truly believe that working together and creating a culture of

cooperation is imperative to improve the quality of care and quality of life for those patients relying on us for their long term care.

Our profession, Mr. Chairman, has made tremendous strides over the past twenty years. However challenges remain and we must be aggressive in addressing them. As we move forward, we must ensure that we are prepared to meet the growing complex care needs of baby-boom retirees, and to do so, our profession requires financial stability which is critical to our continuing progress with quality improvement. That link between stable funding and quality has been noted time and again—by former Secretary of Health & Human Services Tommy Thompson, by former Administrator of CMS Dr. Mark McClellan, and most recently by CMS Acting Administrator Leslie Norwalk whose article for this month's edition of *Provider* magazine states,

> *Nursing home providers have been on the leading edge of this quality movement. Long before hospitals, doctors, home health providers, pharmacies, dialysis facilities and others came to the table, the nursing home industry was out front with Quality First – a volunteer effort to elevate quality and accountability....* Advancing Excellence in America's Nursing Homes *launched last September... builds on the 2001 Quality First campaign and stresses the essential connection between quality, adequate payment for services and financial stability.*

Ms. Norwalk goes on to say,

> *Quality measurement has worked in nursing homes.... Collaborating to measure quality of long-term care, report it, support it, and improve it – that's the best path to a high-quality, patient-centered, provider-friendly system that everyone can afford. At CMS, we look forward to working with you to achieve it."*

Again, we thank you, Mr. Chairman, and this Committee, for providing the long term care community such a timely and valuable opportunity to discuss our ongoing commitment to providing quality long term care and services, and your efforts to foster an environment in which we can continue to work together successfully.

I also wish to commend Senators Gordon Smith and Blanche Lincoln, members of this committee for many years, for putting forward some of the most important regulatory reform concepts of the past twenty years – reforms to the survey and certification process, and other critical reforms that can help to build mutually beneficial partnerships, and undo an era of unproductive confrontation.

The *Long Term Care Quality and Modernization Act of 2006 (S. 3815)* represents an important step toward such a culture of partnership, one that we enthusiastically embrace and endorse, and that I will discuss in more detail later in my testimony.

Twenty years ago, passage of the *Omnibus Budget Reconciliation Act in 1987 (OBRA '87)* ushered in an era of change in our approach to patient care. Congress made the care mandate very clear: all certified facilities must "attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident."

The *OBRA '87* mandate was intended to move care in new directions, and it did.

The law required a comprehensive assessment of each patient using a uniform Minimum Data Set (MDS) – this was groundbreaking. It was equally important that each facility needed to create and use an ongoing quality assessment and assurance committee; this offered a platform from which each facility could evaluate the daily processes and procedures that generate positive patient outcomes. We took that direction and ran with it like no other health care sector.

Even so, in the final analysis, the resident-centered, outcome-oriented, consistent system of oversight that was originally intended bears little resemblance to the reality we have today.

What we have is a system that defines "success" and quality in a regulatory context that is often measured by the level of fines levied and the violations tallied – not by the quality of care, or quality of life, as was the original goal of *OBRA '87.*

We must be mindful here today of the important lessons we have learned since 1987, and be open to the new ideas that will help improve care quality through 2027, and make it better, still, by 2047.

Today, we know far more about promoting quality, and we have better tools with which to measure it than we did twenty years ago. We need to intelligently change the regulatory process to allow and encourage us to use what we have learned – to place quality over process, care over procedure, and most importantly, put patients at the forefront.

Now is the time, Mr. Chairman, to move to such a system.

Comments on the United States Government Accountability Office (GAO) Nursing Homes Report (March 2007)

Mr. Chairman, we take very seriously the newly-released Government Accountability Office (GAO) report being discussed here today – and acknowledge the fact we still have many challenges ahead of us in terms of addressing and improving the nation's most troubled facilities – one patient harmed is one too many and every patient deserves only the best care possible.

Instances of poor care, while rare, are always to be taken seriously and quickly addressed. That is why we are committed to working constructively with Congress, CMS, state survey agencies, and all long term care stakeholders in improving care quality that our seniors and persons with disabilities deserve.

American Health Care Association
1201 L Street NW, Washington DC, 20005

There are mechanisms in place to deal with poor performing providers, and we support transparent processes that ensure improvement in these facilities in the most expeditious manner. AHCA and its members have been in regular dialogue with CMS regarding this issue, and we continue to aggressively pursue avenues where we can work in concert with the federal government to ensure care quality is maximized.

The GAO report also takes note of the critical role CMS plays in overseeing the care provided to frail, elderly, and disabled Americans each day. While the GAO criticizes CMS for not effectively utilizing available sanctions when dealing with persistently poor performing facilities, the report also shows that nationally the percentage of nursing homes being cited for actual harm or immediate jeopardy in recent years has drastically reduced.

From an historical, comparative and frankly, instructive standpoint, let us briefly look at a 2003 GAO report which found an almost 30 percent reduction in actual harm deficiencies over an 18 month period that ended in 2002. It is unclear whether this was due to an understatement of deficiencies as the GAO concluded, or as we would argue an indication of real quality improvement. This dichotomy points to the central problem in understanding today's oversight process, and underscores the inability to distinguish between the failure to identify deficiencies and real quality improvement.

Yet, in assessing the effectiveness of the joint federal-provider *Nursing Home Quality Initiative* (NHQI), our profession's *Quality First* Initiative, and other quality improvement programs now underway for several years, we say proudly and unequivocally they are proving effective. In fact, NHQI data illustrates improvement in key quality measures.

These efforts help place us on the course necessary to ensure care quality continues to improve, and evolves in a manner that best serves patient needs throughout the long term care continuum.

The survey system is designed to assess compliance with Requirements of Participation and to measure quality. However, in practice, it is focused more on process compliance rather than actual patient care outcomes. Our focus needs to return to the patients, their satisfaction, their care outcomes and the degree to which the facility meets their clinical and quality of life needs.

GAO Recommendations for Executive Action

The GAO makes several recommendations in their report – some with which we agree and others we feel will not be in the best interest of patients or the individuals who deliver their care:

- *GAO Recommendation:* Expand CMS' Nursing Home Compare Web site to include implemented sanctions and homes subjected to immediate sanctions.

- *AHCA Position:* We see CMS' web site *Nursing Home Compare* as a valuable resource but more needs to be done to ensure that the data is validated, current, accurate, and displayed in a manner that enhances consumers' understanding and effective use. This

recommendation seems contrary to GAO's own concern related to the accuracy of CMS data systems.

- *GAO Recommendation:* CMS should expand its Special Focus Facility program with its enhanced enforcement requirements to include all homes that meet a threshold, established by CMS, to qualify as poorly performing homes.

- *AHCA Position:* We are supportive of CMS terminating consistently poor performing facilities. However, we believe that CMS' process for determining a Special Focus Facility (SFF) is not transparent, which makes it extremely difficult to ascertain the level of clear standards, established thresholds and the presence of due process. We are supportive of CMS' effort to better define and identify poor performers. We encourage greater cooperation between the Quality Improvement Organizations (QIOs) and problem facilities – it has been demonstrated that such cooperation is effective improving quality patient care.

- *GAO Recommendation:* The CMS Administrator should develop an administrative process for collecting civil money penalties (CMPs) more expeditiously (prior to the exhaustion of appeals) and seek legislation to implement this process effectively.

- *AHCA Position:* We have always advocated for due process in the administrative review. Given significant concerns about the validity of deficiencies, and inconsistency between states in the Informal Dispute Resolution process, we believe skilled nursing facilities should not pay a CMP until determination of fault is finalized. Therefore, we cannot support this recommendation.

- *GAO Recommendation:* Ensure the consistency of CMPs by issuing guidance such as the standardized grid piloted by CMS in 2006.

- *AHCA Position:* We believe that circumstances surrounding noncompliance must evaluated on an individual basis before remedies can be imposed – a standardized CMP grid does not take into account the specific circumstances around noncompliance.

Summary

In total, the increased focus on resident-centered care, actual care outcomes, increased transparency and public disclosure, enhanced stakeholder collaboration and the dissemination of best practices models of care delivery is paying off. Here are some of the facts:

- Key quality indicators tracked by the Nursing Home Quality Initiative have improved since it was launched by CMS five years ago, including:
    - improved pain management,
    - reduced use of restraints,
    - decreased number of patients with depression, and

- improvements in physical conditions such as incidents of pressure ulcers.

- Satisfaction of patients and family members is a critical measure of quality. An independent survey of nursing home patients and their families, conducted by *My InnerView,* indicates that a vast majority (83%) of consumers nationwide are very satisfied with the care provided at our nation's nursing homes and would rate the care as either good or excellent. A soon-to-be-released update to this report will illustrate increased consumer satisfaction.

We face four situations which impede ongoing quality improvements:

First, surveyors simply do not have a clear understanding of the challenges faced daily by the staff of a nursing facility caring for these frail, elderly and disabled patients.

No, this is not a surveyor's job – but a better understanding of a day in the life of a nursing home patient and their caregivers can only benefit the patients for whom survey process is intended to protect.

The Quality Indicator Survey (QIS) pilot now in place is meant, in part, to provide more objective results in application of interpretations. While we are encouraged by the program, increased transparency regarding details of QIS is necessary to assist facilities in understanding and fully supporting this new system. The pilot is currently underway in six states, and its use for all facilities is still several years away. In the interim, improvements in consistency can be addressed through a program that trains both surveyors and providers simultaneously, as well as trains new surveyors within a facility for a period of time so they can experience firsthand the day-to-day operations of a nursing home.

Second, provisions of The Nurse Aide Training and Competency Evaluation Program specify when a facility is prohibited from providing nurse aide training. Criteria automatically triggering such a two-year nurse aide training prohibition include imposing civil monetary penalties in excess of $5,000, imposing the denial of payment remedy, or conducting an extended or partial extended survey – which is required if surveyors find substandard quality of care (SQC).

Although SQC may indicate a serious problem in a facility's care delivery system, there are times when SQC does not indicate a problem that is directly related to the care or safety of patients. In these instances the loss of training is particularly onerous and unfair – especially to residents themselves. If we don't have the ability to train new nurse aides, we are limited in the ability to recruit these potential caregivers, and as we are all aware, quality care is provided by those individuals at the bedside.

Furthermore, as I mentioned, the two-year prohibition is instituted regardless of when the problem is corrected, even if the problem is corrected within a day.

Here's an example: noncompliance with the environmental aspects of quality of life rules – that have little or no impact on patient safety or quality care – could trigger SQC, and therefore a two-year nurse aide training prohibition. This negatively impacts quality far more than it helps.

Third, barriers that currently exist for individuals purchasing problem facilities must be eliminated. In some circumstances facilities have closed or are in imminent danger of closure; one might assume that in certain cases, sadly, the situation might not improve. In those rare cases, Congress and CMS should consider the suspension of certain fines and penalties when a facility is being purchased. This of course assumes that it would be an arms length transaction by an individual or group who have no connection to the previous owner. This will help in two ways: 1) assuming the facility is not yet closed, it may negate the need to transfer patients, which can have serious psychological and medical consequences; and 2) it will encourage individuals and groups to purchase a problem facility in order to improve it by removing insurmountable obstacles at the outset which might otherwise discourage them from making the purchase.

Fourth, we also urge Congress to consider the major problem of workforce in 2007, not only in terms of its reauthorization of the Nurse Reinvestment Act but also in terms of comprehensive immigration reform and developing training programs which establish an adequate, appropriate and well trained domestic nurse aide workforce. Put simply, nursing homes face major obstacles not only in terms of recruitment but also retention of nurses and certified nursing assistants (CNAs). Providing for incentives to create more nurse faculty positions will help colleges create more nursing programs, many of which are already filled to capacity. In terms of immigration, removing the caps for the recruitment of nurses from beyond our borders is an absolute necessity. We need the ability to attract sufficient nurses from the United States to fulfill our capacity. And when it comes to recruiting CNAs, we find ourselves competing with other industries altogether.

So we ask that Congress think carefully about targeted relief to recruit nurses, not only domestically but internationally as well.

Each of these four areas, Mr. Chairman, needs to be reformed with one goal in mind, improving patient care.

We pledge to work with you, Mr. Chairman, and the entire Congress to encourage an environment which continuously improves the long term care services delivered daily to nursing home patients. To this end, we applaud the legislation which Senators Smith and Lincoln introduced in the 109th Congress and hope that such a bill that encourages a culture of partnership is again introduced. This bill would encourage investment in capital improvements and health information technology, foster the creation of a stable and well-trained workforce, address pressing access and financing concerns, ensure essential rehabilitation services are available to those who need it most, and facilitate our ability to sustain continued quality improvements by removing some of the illogical, counterproductive barriers I just outlined.

From a regulatory reform standpoint, Senators Smith and Lincoln's bill would, in summary:

- Require joint training and education of surveyors and providers, and implement facility-based training for new surveyors; and

- Direct CMS to modify the definition of SQC so that factors not affecting quality of care or the training of nurse aides are eliminated, and amend current law to allow nursing facilities to resume their nurse aide training program when deficiencies that resulted in the prohibition of the training have been corrected and compliance has been demonstrated.

On the front lines of care, Mr. Chairman, these proposals are significant, and they merit strong support.

In addition to ensuring the nearly $15 billion, five year Medicare and Medicaid funding cuts are not included in the federal budget, passage of this landmark legislation is our most important legislative priority for 2007.

We have discussed special focus facilities with CMS on numerous occasions. As we have been transparent about our industry, we have urged CMS to be similarly transparent. What do we mean?

There need to be very clear standards that are promptly conveyed to nursing homes across the country. What are the criteria which CMS utilizes to place nursing homes on the list of special focus facilities? When and how have owners and operators been informed? What are the specific steps which a facility must undertake in order to graduate off the list? These are not only issues of due process for the facility, but they also serve as a "roadmap" to get facilities back on the right track.

Each of us here today seeks precisely the same objective, which is to work to improve the quality of long term care – and to do so in a manner that helps us best measure both progress as well as shortcomings.

As I have noted, improving care quality is a continuous, dynamic, ongoing enterprise. While we are enormously proud and pleased by our care quality successes, we concur with all here today there is far more to accomplish.

I can say from all my years in long term care, Mr. Chairman, that there has never been a broader recognition of the importance of quality, or a broader commitment to ensure it keeps improving. Let us all commit today to ensure the systems and methods used twenty years ago to help assess and measure care quality are improved upon and supplemented by new, evolving systems and methods we are just now beginning to explore and assess.

###

American Health Care Association
1201 L Street NW, Washington DC, 20005

The CHAIRMAN. Thank you, Ms. Ousley.
Ms. Christie.

STATEMENT OF MS. ORLENE CHRISTIE, DIRECTOR, LEGISLATIVE AND STATUTORY COMPLIANCE OFFICE, MICHIGAN DEPARTMENT OF COMMUNITY HEALTH, LANSING, MI

Ms. CHRISTIE. Thank you, Chairman Kohl and Members of the Special Committee on Aging, for this opportunity today to testify before you on the Michigan Workforce Background Check Program. As you have stated before, my name is Orlene Christie, and I oversee that program.

In 2004, Governor Granholm and the Michigan Department director, Janet Olszewski, proposed strong requirements to assure the health and safety of Michigan's citizens in long-term care facilities. This project is a priority for the Governor and for the Department Director.

Working cooperatively with the Michigan legislature, the Office of Attorney General and the Centers for Medicaid and Medicare Services, Michigan successfully implemented the Workforce Background Check Program. Through a competitive process, Michigan was also successful in securing a $3.5 million grant to create an effective statewide background check system.

Through the passage of Public Acts 27 and 28 of 2006, Michigan laws were enhanced and improved to require all applicants for employment that would have direct access to our most vulnerable population, the elderly and disabled, to undergo a background check. Additionally, all employees who are hired before the effective date of April 1, 2006, would need to be fingerprinted within 24 months of the enacted laws.

Before the new laws were passed, only some employees in nursing homes, county medical care facilities, homes for the aged and adult foster care facilities were required to have some kind of background check. Prior to 2006, the background checks were less comprehensive and primarily included just a name-based check of the Internet criminal history tool. The FBI's fingerprint check was only required for employees residing in Michigan for less than 3 years.

The previous law also did not require all employees with direct access to residents in long-term care facilities to undergo a background check. Further, for those persons who were subject to a background check, there was no systematic process across the multiple health and human services to conduct the checks to disseminate findings or to follow through on results.

With Michigan's expansion of the laws, all individuals with direct access to residents' personal information—that information can be financial, medical records, treatment information or any other identifying information—are now required to be a part of Michigan's Workforce Background Check program.

The scope of the checks was also enhanced to include hospice, psychiatric hospitals, hospitals with swing beds, home health and intermediate care facility/mental retardation.

Let me explain a little bit about how our program works.

Michigan created a Web-based application that integrates the data bases for the available registries and provides a convenient and effective mechanism for conducting criminal history checks on

employees. Independent contractors and those granted clinical privileges in long-term care facilities, those individuals are now covered under the new laws.

Further, the online Workforce Background Check System is designed to eliminate unnecessary fingerprinting through a screening process. As of April 1, 2007, almost 99,000 applicants have been screened through Michigan's Workforce Background Check Program.

Of the 61,000 or so individuals that a background check was prompted on, about 3,200 were deemed unemployable and excluded from potential hiring pools due to information found on the State lists that include the iChats, the Office of Inspector General exclusion list, the nurse aid registry, the sex offender registry, the offender tracking system, and the FBI list.

The applicants that have been excluded from employment are not the types of people that Michigan could ever afford to hire. These people have contact with some of our most vulnerable population. We have prevented hardened criminals that otherwise would have access to these vulnerable populations from employment.

As Michigan's demographic profile mirrors that of the Nation, the offenses that disqualify individuals from employment in long-term care under the new laws are expected to all be similar across the United States.

Of the criminal history reports that were examined, fraudulent activity and controlled substance violation accounted for 25 percent of all disqualifying crimes. Fraudulent activity, as we all know, includes such things as embezzlement, identity theft and credit card fraud. This is particularly alarming, given the projected increase in financial abuse amongst the elderly.

Accessible to long-term care providers through a secure I.D. and password, a provider is easily able to log on to the Workforce Background Check System to conduct a check of a potential employee. If no matches are found on the registries, the applicant goes on to an independent vendor for a digital life scan of their fingerprints. The prints are then submitted to the Michigan State Police and then to the FBI.

If there is a hit on the State or national data base search, a notice is sent to either the Michigan Department of Community Health or our other agency, the Michigan Department of Human Services, for their staff and our staff to analyze the results of the criminal history.

Michigan has also implemented what we call a ramp-back system, where Michigan State Police notifies the two agencies that I have just talked about of a subsequent arrest and, in turn, the agency notifies the employer. This way, we can assure that, in real-time, as soon as a criminal history record is updated—and that can include an arrest, a charge or a conviction—the Department and the employer will know about it and will be notified.

As I conclude, as a result of Michigan's Workforce Background Check Program, the health and safety of Michigan's vulnerable population is protected by ensuring that adequate safeguards are in place for background screens of direct service workers.

While the vast majority of health care workers are outstanding individuals—and I do want to make that point—who do a wonder-

ful job of caring for people in need, we are extremely pleased that Michigan's Workforce Background Check Program has stopped more than 3,000 people with criminal histories from possibly preying on our most vulnerable population.

By building an appeals process, we also have developed a fair system for reviewing inaccurate criminal records or convictions.

So, as you can see, Mr. Chairman, Michigan has been leading the way in the area of employee background checks. As I indicated before, this project is and has been and will continue to be a priority for Governor Jennifer Granholm and for the Michigan State director, Janet Olszewski.

We appreciate this opportunity to share this information with you today and look forward to our continued cooperation on this vital topic. Thank you.

[The prepared statement of Ms. Christie follows:]

State of Michigan

U. S. Senate Special Committee on Aging

The Nursing Home Reform Act Turns Twenty: What Has Been Accomplished, and What Challenges Remain?

Written Testimony
of
Orlene Christie
Director of the Legislative and Statutory Compliance Office
Michigan Department of Community Health

May 2, 2007

Thank you, Senators Kohl and Smith and the Senate Special Committee on Aging for this opportunity to testify before you today on Michigan's Workforce Background Check Program.

My name is Orlene Christie, and I am the Director of the Legislative and Statutory Compliance Office in the Michigan Department of Community Health. I oversee the Workforce Background Check Program.

In 2004, Governor Jennifer Granholm and the Michigan Department of Community Health (MDCH) Director Janet Olszewski proposed strong requirements to assure the health and safety of Michigan citizens in long-term care facilities. This project is a priority for the Governor and the Department Director. Working cooperatively with the Michigan Legislature, the Office of Attorney General, and the Centers for Medicaid and Medicare Services (CMS), Michigan successfully implemented the Workforce Background Check Program. Through a competitive process, Michigan secured from CMS a $3.5 million grant to create an effective statewide background check system.

Through the passage of Public Acts 27 and 28 of 2006, Michigan laws were enhanced and improved to require all applicants for employment that would have direct access to our most vulnerable populations – the elderly and disabled - to undergo a background check. Additionally, all employees who were hired before the effective date of April 1, 2006, would need to be fingerprinted within 24 months of the enactment of the laws.

Before the new laws were passed, only some employees in nursing homes, county medical care facilities, homes for the aged, and adult foster care facilities required some type of background check. Prior to 2006, the background checks were less comprehensive and primarily included a "name-based" check of the Internet Criminal History Tool (ICHAT). The FBI fingerprint check was only required for employees residing in Michigan for less than three (3) years. The previous law also did not require all employees with direct access to residents in long-term care facilities to undergo a background check. Further, for those persons who were subject to a background check, there was no systematic process across the multiple health and human service agencies to conduct the checks, to disseminate findings, or to follow through on results.

With Michigan's expansion of the laws, all individuals with direct access to residents' personal information, financial information, medical records, treatment information or any other identifying information are now also required to be part of Michigan's Workforce Background Check Program in addition to individuals providing direct services to patients. The scope of the checks was also enhanced to include hospice, psychiatric hospitals, and hospitals with swing beds, home health, and intermediate care facility/mental retardation (ICFs/MR).

How Our Program/System Works

Michigan created a Web based application that integrates the databases for the available registries and provides a convenient and effective mechanism for conducting criminal history checks on prospective employees, current employees, independent contractors and those granted clinical privileges in facilities and agencies covered under the new laws.

Further, the online workforce background check system is designed to eliminate unnecessary fingerprinting through a screening process.

As of April 1, 2006, 98,625 applicants had been screened through Michigan's Workforce Background Check Program. Of the 61,474 applicants that prompted the full background check, 3,262 were deemed unemployable and excluded from potential hiring pools due to information found on state lists such as ICHAT, (U.S. HHS Exclusion List) OIG exclusion list, the nurse aid registry, the sex offender registry, the offender tracking information system, and the FBI list.

The applicants that have been excluded from employment are not the types of people Michigan could ever allow to work with our most vulnerable citizens. We have prevented hardened criminals that otherwise would have access to our vulnerable population from employment.

As Michigan's demographic profile mirrors that of the nation, the offenses that disqualify individuals from employment in long-term care under the new laws are expected to also be similar across the United States.

Of the criminal history reports examined, fraudulent activity and controlled substance violations account for 25 percent of all disqualifying crimes. Fraudulent activity includes such things as embezzlement, identity theft, and credit card fraud. This is particularly alarming giving the projected increase in financial abuse of the elderly.

Accessible to long-term care providers through a secure ID and password, a provider is easily able to log onto the workforce background check online system to conduct a check of a potential employee. If no matches are found on the registries, the applicant goes to an independent vendor for a digital live scan of their fingerprints. The prints are then submitted to the Michigan State Police and then to the FBI. If there is a "hit" on the state or national database search, a notice is sent to either the Michigan Department of Community Health or the Michigan Department of Human Services for staff analysts to examine the applicant's criminal history.

Michigan has also implemented a "rap back" system where the Michigan State Police notifies one of the two state agencies of a subsequent arrest and in turn the agency notifies the employer. This way we can ensure that in real time, as soon as the criminal history record is updated (arrest, charge or conviction), the department and employer are also notified.

Conclusion

As a result of Michigan's Workforce Background Check Program, the health and safety of Michigan's vulnerable population is protected by ensuring that adequate safeguards are in place for background screenings of direct care service workers.

While the vast majority of health care workers are outstanding individuals who do a wonderful job caring for people in need, we are extremely pleased that Michigan's Workforce Background Check Program has stopped more than 3,000 people with criminal histories from possibly preying on our most vulnerable citizens. By building an appeals process, we have also developed a fair system for reviewing inaccurate criminal records or convictions.

As you can see, Michigan has been leading the way in the area of employee background checks. As I indicated, this project has been a priority of Governor Jennifer Granholm and Michigan Department of Community Health Director Janet Olszewski. We appreciate this opportunity to share this information with you today and look forward to our continued cooperation on this vital topic.

Thank you.

The CHAIRMAN. Thank you. Thank you, Ms. Christie.

I would like to ask you, each member briefly, to comment on Ms. Christie's background check program, and would you think that is a high priority, in terms of having a national background check program?

Ms. Harrington.

Ms. HARRINGTON. Yes, I certainly agree. I think it is a very important step forward, and I am very pleased to hear about the Michigan program. I think Federal legislation is in order. A number of States do have it, but there is half of the States that don't.

The CHAIRMAN. Right.

Ms. Hedt.

Ms. HEDT. Yes, we think it is essential.

There are two kinds of abuse and neglect that residents experience. One is from individuals who should not be working in the field, and the other is from neglectful practices, for not having enough staff or not caring for a resident appropriately. This would help very much to handle that first situation.

The CHAIRMAN. Ms. Ousley?

Ms. OUSLEY. Yes, we absolutely have had longstanding policy with the American Healthcare Association that we support background checks, and we are very supportive.

The CHAIRMAN. I would like to ask for your comments on CMS's Nursing home Compare Web site. Many people find that it is not clear how to use it. They don't find the information they are looking for.

For example, you, Ms. Ousley, don't think that it should have a list of sanctions. I guess that is your position, or something like that.

Ms. OUSLEY. I agree that the sanctions should be there. It is simply that we want to make sure that the data is accurate when it goes up, that there are not mistakes.

The CHAIRMAN. Right, and listed for each nursing home the level of staffing and things of that sort.

Is that Web site really important to the public? If so, how can we improve it? Ms. Harrington?

Ms. HARRINGTON. Yes, I think it is really important.

One of the most important aspects of that Web site is the staffing information. Unfortunately, the data for the staffing comes from the survey at the 2-week time period of the annual survey, and it is not audited.

So what we would recommend is that all nursing homes be required to report their detailed staffing data electronically every quarter, and that that be put up on the Web site, and for the full year, rather than just at the time of the survey.

The CHAIRMAN. OK.

Ms. Hedt.

Ms. HEDT. We think it is a very important Web site because it is a sole source for consumers to go to to compare across the country.

There are States that have Web sites that are more consumer-friendly and that have more detailed information. I can provide that to you later.

Years ago in my career, an administrator said to me, "I don't mind paying my civil monetary penalty, but please don't put it in your newsletter that goes out to the public." I think that a lot can be accomplished by making sure that the public knows when facilities have provided poor care and the sanctions that are applied.

The CHAIRMAN. Thank you.

Ms. Ousley.

Ms. OUSLEY. Yes, I think the Nursing Home Compare is extremely important, and we are very supportive of it. As I said earlier, we do want to make sure that that data is accurate, that it is updated frequently.

I also want to say, from OBRA 1987's perspective, I am very proud of the comprehensive assessment that nursing homes do on each and every resident. It is the only sector of health care in America where you can actually go on a Web site and you can see outcomes of care that are occurring. I am proud of that, and I am proud that CMS has it there.

It is difficult to read. It is complicated, and I know that the average consumer has some problem with that. One of the things that I do when I work with nursing home administrators, I encourage them, when families come in to talk about admitting a loved one to the nursing home, that they take the time to explain to that consumer how to read and what it actually means. I think that is very important. I think it is a very important role that an administrator can play.

The CHAIRMAN. Thank you.

Ms. Christie.

Ms. CHRISTIE. I do believe that that information is vital. I believe knowledge is key, and with that type of tool that anyone can access, people can have a better understanding and a better knowledge in terms of where their loved ones are being sent and what kind of care they are getting.

The CHAIRMAN. Thank you.

Senator McCaskill.

Senator MCCASKILL. Thank you, Mr. Chairman.

One of the things that I think we struggle with in this area is, first, the staffing levels and whether we need mandatory staffing. I didn't know how many States have mandatory staffing levels. I should know that, but I have not been focused on the whole Country for very long. So, pardon my ignorance as to how many States have it. But I think, obviously, the staffing issue is paramount and very, very important, and the nurse component of that, also.

The other thing that I think I mentioned previously is the acuity level, and the vast differences there are between various facilities in terms of what percent of their population is ambulatory versus non-ambulatory. What is the acuity level they are dealing with? All nursing home facilities are not created equal, in terms of what type of population they are dealing with on an ongoing basis.

I know that there has been discussion about this, and I would certainly, for both Dr. Harrington and Ms. Hedt, what are your feelings about—I think the cost containment centers, that is a great way of getting at the issue, but I didn't hear an acuity cost center in there.

It is much more expensive and requires much more staffing to deal with the more seriously needy clients in long-term care as opposed to those who aren't. What can we do at the Federal level to begin to address reimbursement levels on the basis of acuity, so that those homes that have the more aggressive acuity patients maybe are not getting the same reimbursement as those who won't take those more difficult clients.?

Ms. HARRINGTON. Yes, I think that is a very good point, that acuity needs to be taken into account when you estimate staffing. In fact, the Medicare rates do take into account acuity. It has all the different case mix levels when it calculates the Medicare rates.

Senator MCCASKILL. The Medicare or Medicaid?

Ms. HARRINGTON. Medicare. Then, about half of the States have acuity built into the State rate.

The problem is that, once these rates are given out, set for each facility, then the nursing home is allowed to spend the money the way they want. So they don't have to spend it on the staffing to address the acuity that they were given the right for. So that is the flaw.

Senator MCCASKILL. In the States that have acuity built into their reimbursement rates—we certainly don't in Missouri. For those that do have acuity in their reimbursement rates, are those audited? If so, how?

Ms. HARRINGTON. Yes, the States that have case mix reimbursement usually do have some auditing procedures. They may need to be more extensive.

Senator MCCASKILL. Because my fear would be that they would come in with a high acuity, and then it would be a very—then, for whatever reason, either by circumstances or by planning, that that acuity level would drop, and that the reimbursement rate would remain high, or vice versa. How do we get at that?

Ms. HARRINGTON. Well, most States only set their rates once a year, so they don't necessarily adjust during the year. They probably figure it averages out.

Senator MCCASKILL. Missouri went, I think, a decade without resetting its rates, so I would like the idea that rates would be readjusted on an annual basis. How many States adjust on an annual basis?

Ms. HARRINGTON. I actually don't know right now.

Senator MCCASKILL. Wow. That would be great.

Ms. HARRINGTON. Most States do have a rate increase on an annual basis, but the rate increase is more tied to how much money the legislature feels they have that year for the cost-of-living increases, rather than looking at the acuity.

But the problem is that most States don't have very good mechanisms for auditing, so the money is not necessarily spent on what it is intended for. This is what I am raising as the key issue.

Ms. HEDT. From our perspective, the minimum staffing standard is just that, it is a minimum standard, and that would need to be adjusted for increased acuity of the residents that are there.

We are absolutely mindful of the need for financial resources to care for people, depending on the level of care that they need, but we strongly believe that funding has to be spent close to the resi-

dent as opposed to corporate profits or high salaries of the executives.

We need to make sure that the workforce has health care benefits, an adequate living wage, as well as appropriate supervision and is a part of that planning for individualized resident directed care.

Senator MCCASKILL. I am trying to pick the ones I want, because it is hard for me to narrow it down in a short period of time of all the things I would like to talk about.

I would like to talk more about the background check, and I think there is absolutely no excuse that background checks are so difficult across this country right now, with the technology we now have available to us.

I know that in Missouri we had several audit findings on background checks. Frankly, there was this huge backlog of background checks, and it was because we had put into place a new carry-and-conceal weapon law, and so they were trying to decide which checks were more important, the people who wanted to carry a weapon all the time or the people who were caring for elderly or the mentally ill in our State. It was really a huge public policy issue and problem.

But in terms of the surveys, I think that the Web site is great, where consumers can potentially compare nursing homes on a number of different bases in terms of making a decision. I understand the need for the data to be accurate.

The problem I have with those is that so much of it is based on the annual survey. Where I come from, it is pretty hard not to know when your annual survey is going to be. I am not sure that the information we get from annual surveys is what we need it to be. There is no question that there have been incidents that where facilities have staffed up for the annual survey, and staffed back down when annual survey was over.

I would like the reaction of the panelists as to the potential of mandating the annual survey on a spot basis, so that no one knows when the annual survey is going to occur, that the folks that are doing the annual survey show up at the facility unannounced and without any kind of prediction as to when they are going to be there.

We found the problem was so bad at one point in Missouri that not only were the annual surveys predictable, every survey was predictable. I mean, every check, whether it was a follow-up, everybody knew always when the State was coming. We weren't getting a realistic look at what true care on the ground was because of the predictability of the survey time.

So if you all would address that in terms of the predictability of the annual survey and the lack of an accurate glimpse of what the standard of care really is in that home. Because everyone spiffs up, polishes up, paints, gets everybody there just to prepare for the annual survey.

Ms. HARRINGTON. Absolutely, I agree. They need more frequent surveys. We think they need at least an annual survey at a minimum. But part of the problem is the resources that the agencies have. They don't even have enough resources to do their complaint investigations, in many cases.

So I think that increasing the Federal resources so that they could have more frequent surveys, especially of these poor-performing facilities, would make an enormous difference.

Senator MCCASKILL. Should we require that they be surprised?

Ms. HARRINGTON. Yes, absolutely.

Ms. HEDT. That is part of what should be happening now. In reality, it isn't happening. But residents tell us, and family members, that the more surveys that take place at night, the more surveys that take place on the weekend, the better picture they are——

Senator MCCASKILL. Right. That was one of our findings, that there was never an investigation that occurred in the dark of night. Now, this has been several years ago. I think they have begun doing that now. I think they have improved on that in Missouri.

Ms. HEDT. Yes, there is a required percentage, a minimum goal that the State should be doing at night and on weekends.

That being said, we want to make sure that all facilities are surveyed on a consistent basis so that it is not more than a year when a facility receives a survey. Partly, that is why facilities know they are going to get a survey now, because it is every 9 to 15 months, and so we know it is going to happen. It is not necessarily that they are being told.

The key to it is that facilities should always be prepared for a survey, and be meeting those basic nursing home reform law requirements all the time.

Senator MCCASKILL. I get that, that if you have to do it once a year, everybody kind of knows when it is going to be. But to me, it seems like the value we get out of maybe a facility having a survey in January and then being surprised by having another survey in June would more than overcome in terms of the kind of inoculating effect that would have on the whole industry, would more than overcome the fact that maybe one wasn't going to get one except once every 18 months.

You see what I am saying? The lack of predictability overall I think would have such a positive impact that it would make up for the fact that maybe everyone wasn't getting in right around the 12- or 13-month mark.

Ms. OUSLEY. Well, both Alice and I spoke to the issue of quality improvement and quality management in facilities. Quite honestly, if a facility has a well-functioning quality management program that takes into consideration the entire operations and all of the requirements, it makes no difference. It should never make any difference when a facility is surveyed.

Again, I go back to the comprehensive assessment that OBRA 1987 brought, and the survey methodology around outcomes. That is to be an overtime evaluation, that when a surveyor comes in, they are to look at: What did this patient look like the day they came to this facility, and what do they look like now? Did facility practice help them get a lot better, or has facility practice made them not get well or actually decline?

If you do that correctly and look at the outcomes, it really doesn't matter. If everyone feels more comfortable with a more frequent survey, more power to it.

I do want to speak to an issue that Dr. Farris said, and that was the new quality indicator survey process that is being piloted now

by CMS. This would be a way that, actually, this software can be made available also to nursing home providers, and they can use it as part of their quality management program.

Have an ongoing assessment at all times so that, when something starts to go a little bit wrong, you can get that fixed quickly, and you understand that the regulations are not for surveyors. They are for making sure that we give good patient care every single day.

Ms. CHRISTIE. Senator, while I am not the most appropriate person to answer your specific question, I do know that those conversations are being held at levels higher than myself, and I will be more than happy to go back and get the information that you are requiring.

Senator MCCASKILL. OK.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator McCaskill. Your contributions have been really good to this hearing because of your background, your experience, and the questions that you have asked.

We would like to thank the second panel. You have been outstanding and made real contributions in our ongoing efforts to improve the quality of care in nursing homes across this country.

I would note that what you had to say and your testimony was relevant enough so that I would note that our first two panelists stuck around, which is not always true at hearings.

So we thank you for staying around, and we thank you for your contributions.

We thank you all for being here, and this hearing is closed.

[Whereupon, at 12:05 p.m., the Committee was adjourned.]

APPENDIX

PREPARED STATEMENT OF SENATOR GORDON SMITH

I want to thank Senator Kohl for holding this important hearing today. The issue of nursing home quality and safety has long been an issue of particular interest for me and I thank the panelists for being here today. The essential work that they do whether it is monitoring or evaluating care, providing care or advocating for nursing home residents, supplies the framework that helps so many of our elderly family members age with dignity.

We are here to look at the Nursing Home Reform Act, also called OBRA '87. This Act was created more 20 years ago to ensure quality care for the now more than 1.7 million nursing home residents in America. By signing this bill into law, President Reagan, along with Congress, indicated that the Federal government has responsibility to ensure the health and safety of nursing home residents. It is a responsibility that I take very seriously, as I know my colleagues do.

We are a nation that is living longer than ever before. With the baby boomers, we will see an exploding elderly population. This surge will only compound any safety or quality issues currently in the system. That is why I look forward to continuing to work with the advocacy community, nursing home care providers and the Centers for Medicare and Medicaid Services (CMS) to ensure the capacity and quality standards meet our current needs and adequately anticipate the needs of the future.

I believe that all stakeholders must work collaboratively to solve problems within the system. In fact, I am currently working with Senator Lincoln to reintroduce the "Long-Term Care Quality and Modernization Act," that we first proposed in the 109th Congress. This bill encourages improvements to nursing homes and the long-term care system generally. I look forward to continuing to work with many of the advocates, care providers, and regulators here today to continue to improve and to ultimately pass this legislation.

Some good news is that nursing home quality has improved since 1987. The GAO has reported in their March 2007 study that the number of serious deficiencies in the four states they examined has decreased between 2000 and 2005. I understand that national data shows a similar downward trend. This is to be applauded. However, we must not rest on our laurels. With about 22 percent of nursing homes still out of compliance with Federal standards—more improvement are necessary.

The past two decades have revealed a true culture shift occurring within the world of long-term care, including services that put the patient at the center of care, encourage inclusion of families in decision-making and giving more choices in the location of the care, such as community-based and in-home care.

In fact, my home state of Oregon is a leader in helping elderly and dependent persons remain in their homes as they age and/or require more hands on care. The vast majority of Americans want to retain their independence and remain in their homes. Because of this culture change, they are able to do that now more than ever. Federal programs and funding should continue to move in this direction.

However, while our elderly are being given more choices in their care, we know that there will always be a section of the population that is too frail, too dependent upon services, to remain in their homes and communities. Nursing homes become the option that can most suit their needs. Nursing home residents are some of the most vulnerable people in our nation. Some have families that can help monitor their care, but many do not. These people depend upon the care providers and the regulators to ensure they are receiving the services they need.

Some of the reports that we will discuss today, including the most recent by the Government Accountability Office (GAO), point out the bad actors within the nursing home industry. Today we must look at these actors and determine what we can do to either help them perform at a much higher level and with consistency, or look at ways they can phased out of the system. We must also look at how the closing

of these facilities would affect the patients they serve and communities in which they are located.

I am confident that our panel of experts will help to answer these questions. I want to thank all of our witnesses for being here today and for their tireless work to improve quality of care for all who reside in our nation's nursing homes.

RESPONSES TO SENATOR SMITH QUESTIONS FROM KATHRYN G. ALLEN, GAO

Question. GAO identified in its 2005 report on nursing home enforcement that CMS's efforts have been further hampered by an expanded workload due to increased oversight and initiatives that compete for staff and financial resources. The latest GAO report identifies that we are still not succeeding in removing the worst offenders from the system. How could CMS refocus its energy on oversight tasks and initiatives to target the real underperformers?

Answer. In our March 2007 report, we recommended two actions, among others, the Centers for Medicare & Medicaid Services (CMS) could take to provide more effective oversight of poorly performing nursing homes.[1] First, we recommended that CMS strengthen the criteria for terminating homes with a history of serious, repeated noncompliance by limiting the extension of termination dates, increasing the use of discretionary terminations, and exploring alternative thresholds for termination, such as the cumulative number of days that they are out of compliance with federal quality requirements. Second, we recommended that CMS consider further expanding the Special Focus Facility program which still fails to include many homes with a history of repeatedly harming residents.[2] In commenting on a draft of that report, CMS also agreed to collect additional information on complaints for which data are not reported in federal data systems, which will help CMS to better identify and deal with consistently poorly performing homes.

In addition, a GAO report issued after the Committee's May 2, 2007, hearing recommended that CMS take two actions to ensure that available resources are better targeted to the nursing homes and quality-of-care areas most in need of improvement.[3] First, we recommended that CMS further increase the number of low-performing nursing homes that Quality Improvement Organizations (QIO) assist intensively.[4] Second, we recommended that CMS direct QIOs to focus intensive assistance on those quality-of-care areas on which homes need the most improvement.

Question. As a Commissioner with the National Commission for Long Term Quality Care, I have heard stories of good actors being punished for precisely the innovation we want them to encourage. For instance, I was told of a facility that is well known for treating pressure sores. Because of their innovation, they receive patients from other facilities who have persistent pressure sores. However, when they are evaluated, the number of patients with pressure sores is then counted against them. Have you heard of stories like this and what do you recommend can be done to encourage innovation and good actors?

Answer. As you indicated, some nursing homes specialize in wound care, such as treating pressure sores. The nursing home quality-of-care requirement pertaining to pressure sores focuses on the care a nursing home is providing a resident with a pressure sore. It specifically states that a nursing home must ensure that a resident who enters a home without pressure sores does not develop any unless the individual's clinical condition demonstrates that they were unavoidable and a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores.[5] As such, a nursing home should not be cited for a deficiency in quality of care simply because residents have pressure sores. A deficiency in quality of care does exist, however, if the nursing home is providing inadequate treatment to residents with pressure sores.

---

[1] GAO, *Nursing Homes: Efforts to Strengthen Federal Enforcement Have Not Deterred Some Homes from Repeatedly Harming Residents,* GAO–07–241 (Washington, D.C.: Mar. 26, 2007).

[2] Special Focus Facilities are subject to two standard surveys each year rather than annually and may be terminated from participation in the Medicare and Medicaid program if they do not show significant improvement within 18 months. In December 2004, CMS expanded the program from about 100 homes to about 135 homes.

[3] GAO, *Nursing Homes: Federal Actions Needed to Improve Targeting and Evaluation of Assistance by Quality Improvement Organizations,* GAO–07–373 (Washington, D.C.: May 29, 2007).

[4] CMS contracts with QIOs to work with providers such as hospitals and nursing homes to improve the quality of care provided to Medicare beneficiaries in each state, the District of Columbia, and the territories.

[5] CMS, *State Operations Manual,* Appendix PP—Guidance to Surveyors for Long Term Care Facilities, § 483.25(c).

Question. While I want to ensure quality care for patients in nursing facilities, I am concerned that if we close facilities that are consistently underperforming that we may cause more harm to patients. I am concerned that if a facility in a rural or very low income area is closed that patients will be at risk of not receiving care at all in those areas or being relocated away from their families and support networks. In your studies, where are most of the poor performing facilities, and if they are in rural and low-income areas, do you think that there is a real risk of a negative impact on resident care?

Answer. We have not reported on geographic distribution of all poorly performing nursing homes. In our March 2007 report, we assessed whether there were alternative placements for several poorly performing homes in our sample from four states and found that there were alternative homes in the vicinity. As I testified before this Committee on May 2, we acknowledge that terminating a nursing home from participation in Medicare and Medicaid can cause concerns about relocating residents to another home, including the adverse effect known as transfer trauma; however, we believe that such concerns must be balanced against the actual harm to residents as a resulting from poor quality care if they continue to reside in a perpetually poorly performing home.

Question. One issue that I have heard discussed concerning the survey process is that surveyors may not report on some deficiencies because they consider the penalties too onerous for the facilities. Is this an issue that you have studied and have you heard surveyors mention any concerns to this affect?

Answer. We have not reported on this issue. In commenting on a draft of our March 2007 report, however, CMS expressed concern about whether its policy of immediate sanctions for homes with serious deficiencies on consecutive surveys actually discouraged the citation of serious deficiencies. We are currently examining the understatement of serious deficiencies during state surveys, a study requested by Senators Kohl and Grassley. As part of our work for this study, we are planning a Web-based survey of state surveyors concerning the factors that may influence the deficiencies they cite.

RESPONSES TO SENATOR SMITH QUESTIONS FROM RANDY FARRIS, CMS

Sanction Effectiveness?

The Government Accountability Office (GAO) has identified that while CMS has attempted to improve both the collection and deterrent effect of civil money penalties (CMPs) that serious problems still exist that call into question the CMPs' effectiveness. CMS even commented in GAO's recent report that providers view CMPs as the "cost of doing business" and are tantamount to a "slap on the wrist".

Question. In addition to improvements to the actual policy, what is CMS doing to assess the enforcement capability of this particular sanction in light of these comments?

Answer. CMS' examination of our enforcement effectiveness in the area of Civil Money Penalties (CMPs) has been primarily along 2 tracks:

1) potential refinements to CMP maximum amounts, and
2) refinements to the decisionmaking process on imposing the CMPs.

Our recent pilot and evaluation of the CMP Analytic Tool addresses the latter track. The imposition of a CMP is an optional remedy under the Nursing Home Reform Legislation promulgated in 1987. We have issued the CMP Analytic Tool. The Tool includes a scope and severity framework for CMS Regional Offices to monitor enforcement actions, communicate with States, address outliers that significantly depart from the norm, and improve national consistency.

To improve national consistency for this remedy, CMS' guidance also includes a scope and severity framework for CMS to (a) monitor enforcement actions, (b) facilitate communication with States, and (c) address outliers that significantly depart from the norm.

We expect the guidance and the CMP Analytic Tool to mitigate the extent to which civil money penalties tend to cluster at the lower end of the allowable range, particularly for nursing homes with repeated, serious quality of care deficiencies.

With regard to the argument that CMPs may simply be viewed as a "cost of doing business" (and may therefore be ineffective as a motivator to improve or as a deterrent to quality lapses), we are examining additional enforcement techniques that apply a combination of sanctions rather than so much reliance on just one type of sanction. An example is a combination of CMP and denial of payment for new admissions. While we believe CMPs do indeed function as a motivator, attention-driver, and deterrent for most nursing homes, we are concerned that CMPs may lose much of their effectiveness for those providers with the lowest levels of compliance.

An important initiative for testing and tracking the effectiveness of multivariate enforcement action is our Special Focus Facility initiative that focuses on those nursing homes with the most deficiencies. CMS' *2007 Nursing Home Action Plan* describes these and other initiatives. The *Action Plan* may be found at *http://www.cms.hhs.gov/CertificationandCompliance/12—NHs.asp#TopOfPage*

Is a Statutory Fix in Order?

One of the bigger problems with CMPs is the delay in receipt of payment because of the statutory requirement that requires exhaustion of all administrative appeals before collection of the CMP. This makes the deterrent effect of the final all that more attenuated. GAO has recommended that CMS consider the provision on CMPs in the Surface Mining and Reclamation Act of 1977, which requires that the mining operator either pay in full the fine or place the proposed amount in an escrow within 30 days that is held until the resolution of an appeal.

Question. Has CMS considered the effectiveness of a pre-appeal payment or escrow account option? Would that offer a greater deterrent effect that fits within the spirit of the CMPs?

Answer. We do not currently have the authority under the Social Security Act to collect CMPs prior to the appeals hearing and determination. We agree that collecting CMPs during the period of an appeal likely would have a greater deterrent effect.

The Federal/State Disconnect

In the most recent GAO report on nursing home enforcement, one of the findings that struck me was the level of disconnect between CMS here in Washington and the regional offices and state agencies that are tasked with implementing that statutes and guidelines regarding the nursing home industry.

Question. From your perspective as a CMS Regional Administrator, can you comment on this discrepancy and offer a few ideas on how this can be remedied so that everyone can get on the same page and work towards more uniform enforcement and oversight?

Answer. In a large program of national scope, we seek to ensure all agencies are aligned through major efforts such as:

(a) a very detailed State Operations Manual (SOM) that specifies the manner in which statutes and regulations are to be applied,

(b) 40–60 publicly available Survey & Certification letters each year to communicate consistent approaches to surveys and clarification of important policy issues,

(c) extensive training programs to orient both State and federal surveyors (especially new surveyors),

(d) weekly conference calls between survey and certification central office leadership and leadership in the CMS regional offices.

We also bring CMS (both central and regional offices) and States together to identify and develop strategies for improving communication and consistency. Annually, CMS hosts a Leadership Summit that brings together State survey agency leadership as well as management representatives from all ten CMS regional offices. CMS Regional Offices bring States together on a regular basis and conduct monitoring visits. The CMS also participates in the annual Association of Health Facility Survey Agencies (AHFSA) conference. AHFSA is the association made up a State survey agencies throughout the country.

As described previously, CMS also publishes an annual *Action Plan* which serves as a blueprint for initiatives CMS will undertake. The CMS *2007 Nursing Home Action Plan* provides several initiatives that:

- Improve how nursing home surveyors interpret specific nursing home requirements. We have revised surveyor guidance for selected regulatory requirements that relate to quality of care through an interactive process with nationally recognized experts and stakeholders;
- Develop a national surveyor training tool for use in training regional and State surveyors;
- Refine State Performance Standards to ensure uniform monitoring of State performance;
- Expand training opportunities for surveyors to better equip them by increasing the number of available courses, adding more geographic sites for training and by adding web based training; and
- Develop a triage policy to guide States in determining whether a discretionary Denial of Payments for New Admissions is imposed or a termination date is set earlier than the time periods required by law.

CMS recognizes the need for assertive leadership and actions to ensure all the principal enforcers are steadfast in application and uniform in execution of remedies imposed. We welcome the interest and support of Congress in all of these efforts.

RESPONSES TO SENATOR SMITH QUESTIONS FROM CHARLENE HARRINGTON, UCSF

Staffing Issues are Budget Issues

Question. I understand that you have participated in the drafting of several recommendations to the Administration on ways to increase staffing levels, while making the fiscal impact less onerous.

Can you share a few of the most feasible recommendations with the Committee, including the timeframe for implementation and any administrative needs or changes such recommendations would require?

Answer. As noted in my testimony, a study by Abt Associates for CMS (2001) reported that a minimum of 4.1 hours per resident day were needed to prevent harm to residents with long stays (90 days or more) in nursing homes. Of this total, .75 RN hours per resident day, .55 LVN hours per resident day, and 2.8 NA hours per resident day were reported to be needed to protect residents. The report was clear that residents in homes without adequate nurse staffing levels faced substantial harm and jeopardy. In order to meet the total 4.1 hours per resident day, 97% of homes would need to add some additional nursing staff. Based on this report and a strong body of research evidence, there is a clear need to increase the minimum staffing standards for nursing homes.

One way to increase staffing is to increase state Medicaid reimbursement rates. My latest study shows that Medicaid reimbursement rates would need to be increased by $90 per resident per day in order to encourage nursing homes to voluntarily increase staffing levels. At this point, many states are struggling with budget deficits and financial problems so they are unlikely to be willing to raise rates this high.

A more effective approach is to have the federal government and/or state governments increase the minimum requirements for registered nurses, licensed nurses (RNs and licensed practical nurses), and total nursing staff. Florida has increased is total nursing requirement to 3.9 hours per resident day and increased its Medicaid nursing home payment rate to cover this increase in staffing. Other states might be willing to increase the total nursing requirements if the federal government would give the state some financial incentive to do so. Certainly the federal government could take an important step forward by embracing higher staffing standards and encouraging states to raise their standards.

Federal legislation could be used to increase its minimum licenses staffing standards to the level recommended in the Abt study (1.3 hours per resident per day) including a requirement for 24 hours registered nurse staffing in nursing homes. The question is whether reimbursement rates would need to be increased to meet this higher standard. Certainly the current Medicare reimbursement rates appear to be adequate to cover the Abt standards without a rate increase (based on GAO and MedPac reports). Medicaid reimbursement may need to be raised to meet the higher standard. Congress could ask each state to determine whether Medicaid rate increases would be needed and could pay for half or more of these costs in its Medicaid cost sharing arrangements.

Question. In your testimony, you recommended that CMS utilize the sanctions of receivership and temporary management procedures relating to facilities with repeated poor performance. Is there a proven track record of success with this type or reorganization and if so, do you have any data on how a change of ownership effects the quality of care in an underperforming facility?

Answer. Since temporary management is already an option under OBRA 1987, some states have used temporary management and receiverships procedures with poor performing facilities. California, in particular, has used this approach a number of times until facilities were sold, closed or brought back into compliance. These approaches have proven effective and yet states have often been reluctant to use them because of the amount of time and resources required to implement this approach. If the federal government were to assume the full costs for temporary management, states would be more likely to use this option.

The success of the procedure depends upon either forcing an owner to come into compliance or attracting a reputable, high quality owner to purchase a facility. States need to be careful to review the credentials of potential buyers to make certain they have a good reputation for high quality of care before they approve an ownership change to ensure that the change will be an improvement over the poor performing facility.

Question. Is there a danger that we are setting up new management too fail since the fines and sanctions from the previous poor performing management would carry over to the new management?

Answer. The state and federal survey agencies could levy the fines and sanctions on the poor performing facility but forgive these fines and sanctions if the facility

obtains a new owner. Generally, the issue of previous fines and sanctions are something that are negotiated as a part of the purchase price paid by a new owner.

Question. Your testimony discussed the potential positive impact of applying cost centers to nursing facility funding as a way to ensure that certain operations, especially staffing, are properly funded. Is there a concern that this kind of oversight could negatively affect a nursing home's flexibility in caring for its residents? Could the formula be too restrictive and not account for different operating plans?

Answer. This approach of establishing cost centers would prevent facilities from taking funds allocated for staffing, therapy and direct care to use for capital improvements, administration, and profits. Certainly accountability is a critical factor in the use of public funds. The Centers for Medicare and Medicaid Services would need to develop a clear procedure for allocating funds for the different established cost centers and for oversight. The debate would then focus on the amount of funds allocated to the different cost centers. Some nursing homes are making excessive profits by reducing direct care to residents and this clearly should be unacceptable.

RESPONSES TO SENATOR SMITH QUESTIONS FROM ALICE HEDT

Question. Fire Safety. How would you recommend CMS and nursing facilities proceed with making fire safety improvements that will be effective but not cost prohibitive?

Answer. Senator Smith, NCCNHR appreciates the opportunity to address an issue that has been especially troubling to nursing home consumers and to the Senate Special Committee on Aging for more than 30 years: Fire safety. NCCNHR and its members are very concerned about the serious deficiencies in fire safety regulation and enforcement revealed in a GAO report, a USA Today investigation, and two tragic multiple-death fires in Connecticut and Tennessee—because we know from experience that public regulation and effective enforcement prevent deaths.

Progress in fire safety regulation has dramatically improved the protection of nursing home residents from fire injuries and death in the years since Medicare and Medicaid were enacted. Two years before the aging committee published its 1975 paper, "The Continuing Chronicle of Nursing Home Fires," 51 people had been killed in multiple-death nursing home fires, an increase from 31 the year before. Today, however, multiple-death nursing home fires on this scale occur less frequently because federal and state regulation have improved safety—particularly in newer facilities, where federal law now requires automatic sprinklers, and in states that require automatic sprinkler systems in all nursing homes. Unfortunately, the tragic deaths of 31 residents in Nashville and Hartford in 2003 remind us that residents are still unnecessarily at risk of dying in a fire in several thousand Medicare and Medicaid-certified facilities that are not required to have automatic sprinklers. Their deaths are a reminder that fire safety is part of the unfinished business of the Nursing Home Reform Act.

According to CMS estimates, there are about 3,700 nursing homes in the United States that do not have sprinklers or that are only partially sprinklered. NCCNHR supports prompt implementation of CMS's proposal of October 27, 2006, to require all nursing homes to be fully equipped with automatic sprinklers. Our comments on the proposed regulations which were endorsed by 66 national, state and local organizations—are attached.

NCCNHR has supported legislation to provide low-cost loans or grants to nursing homes that need financial assistance to install sprinklers. However, we do not believe that costs should deter the federal government from implementing this basic safety requirement that is already decades overdue. We urge you to consider the following:

- The costs are not unreasonable for an industry that annually receives $73 billion in Medicare and Medicaid funds (almost $50 billion of it from the federal government) to provide care for people who are among the most vulnerable to injury or death in case of fire. CMS estimates that it would cost an average-size or small-size nursing home 0.8 to 1.2 percent of its revenues over a five-year period to become fully sprinklered. Only 821 nursing homes do not have any sprinklered areas, according to CMS estimates, that would require installation of sprinklers throughout the building(s).
- The nursing home industry is profitable and can afford to meet essential safety requirements. After 16 residents died in a National HealthCare nursing home in Nashville in 2003, the corporation announced that it would install sprinklers in all of its facilities that did not have them. In the third quarter that year, the company's earnings increased by more than 23 percent over the same period the year before (not accounting for losses from the fire), and it has continued to show substantial

gains in net income. In May 2007, National HealthCare reported increased quarterly earnings almost 30 percent higher than the same quarter in 2006.

• Poor care is always costly. In addition to the loss of life, nursing home fires increase medical expenses, the burden on firefighting departments, and liability costs, and they result in substantial property damage and loss. They may also leave shortages of Medicare and Medicaid beds in a community.

Sprinkler installation is not a problem in many states—nursing homes simply have to have them to obtain a license to do business. All nursing homes in Oregon and a dozen other states are fully sprinklered, according to the American Health Care Association, and six other states have at least 95 percent of their facilities fully sprinklered. Several states are in the process of implementing automatic sprinkler requirements for all their long-term care facilities, including, in some cases, assisted living and personal care homes.

Thank you again for the opportunity to address this issue. NCCNHR urges you to support prompt implementation of CMS regulations to require automatic sprinkler systems in all nursing homes that receive federal funding.

RESPONSES TO SENATOR SMITH QUESTIONS FROM MARY OUSLEY, AHCA

Question. Will More Regulation Help?

Answer. More guidance is unlikely to help and actually could result in more confusion. AHCA believes that joint training for surveyors and providers is key to ensuring there is uniform interpretation of CMS' guidance. While nothing can guarantee each surveyor and each provider will interpret CMS guidelines in the same way every time, presenting the information simultaneously and allowing for both questions and discussion is more likely to ensure that surveyors and providers share a mutual understanding of what is necessary for a facility to be in compliance with the regulations.

In fact, Section 101 of, *The Long Term Care Quality and Modernization Act (S. 1980),* directs the Secretary of Health and Human Services to conduct a 5-state, 2-year demonstration program to establish a process for joint training and education of surveyors and providers as changes to regulations, guidelines and policy are implemented. Following the demonstration, the Secretary would be required to report to Congress on the program's results, including the program's impact on the rate and type of deficiencies that nursing homes participating in the demonstration compare to a state's other facilities (not participating in the demo). S. 1980 is sponsored by three members of the Senate Special Committee on Aging—Blanche Lincoln (D–AR), Gordon Smith (R–OR) and Susan Collins (R–ME).

Question. Foreign Nurse Recruitment

Answer. There is no simple policy to ensure that increasing the number of available nurses would directly benefit long term care. Still, eliminating artificial caps on work visas for foreign-born nurses would improve the current nurse shortage facing all health care providers, including long term care. A 2002 AHCA study examining staff vacancy rates in our nation's nursing homes found approximately 52,000 Certified Nursing Assistants (CNAs)—those who provide 80% of direct patient care—are needed now just to meet existing demand for care. AHCA's study also estimated an additional 13,900 Registered Nurse (RN) and 25,100 Licensed Practical Nurse (LPN) positions remain vacant in nursing homes across the country. The shortage of available employment-based visas for nurses, primarily from India and the Philippines, severely limits the ability of nursing home providers to fill those vacancies.

Another challenge long term care providers face, especially skilled nursing facilities, is competing for a limited number of nurses. More than 80% of nursing home residents rely on either the Medicare or Medicaid funding to pay for the care and services they need, so long term care providers depend upon regular and systematic cost of living increases (e.g., annual market basket update to SNF Medicare funding) in order to compete with other care settings that often can afford to pay higher wages to recruit and retrain skilled caregivers. Without adequate and stable funding—and recognition by states to provide Medicaid reimbursement that at least covers the cost of care for SNF residents—SNFs are unlikely to be able to afford to offer a more competitive wage to both foreign and domestic nurses in long term care.

RESPONSES TO SENATOR SMITH QUESTIONS FROM ORLENE CHRISTIE

Staff and Resident Background Check

Question. Michigan, along with six other states, is participating in the initial pilot program on background checks for employees that work in long term care positions (except for adult foster care). I understand from my staff that the initial response to the program is very positive, and that Michigan is becoming a leader in this area.

Answer. Our program does not include adult foster care.

Question. Recognizing the program is still in its early stages, can you provide any insight into how long term implementation of a background check program will contribute to better quality of care and greater security for those in residential or other forms of long term care?

Answer. The criminal history record is a tool that can be used to identify those individuals with a propensity for criminal behavior and our laws prevent them from working in long-term care facilities. Greater security results from reduced opportunity and access to vulnerable adults. Over time, the long-term care workforce will be comprised of individuals with either no history of relevant crimes or a history that shows no offenses after the effective date of the laws. The background check program shines a light on the behavior of caregivers and elevates the status of vulnerable adults in our society. The very existence of the program sends a clear message that we will not tolerate abuse, neglect or exploitation by caregivers.

Question. Does the background check program screening include offenses committed outside the state or jurisdiction initiating the search?

Answer. Our program includes a national fingerprint-based criminal history search.

Question. What happens if there are records of abuse from prior employment that did not rise to the level of a criminal offense?

Answer. Our law prohibits employers from hiring, contracting with or granting clinical privileges to an individual who has been the subject of a substantiated finding of abuse or neglect or misappropriation of property by a state or federal agency pursuant to an investigation conducted in accordance with 42 USC 1395i–3 or 1396r. A search of the Michigan Nurse Aide Registry and the OIG exclusion database is done as part of the screening process.

DOI: 10.1111/j.1475-6773.2006.00641.x

Nurse Staffing Levels and Medicaid Reimbursement Rates in Nursing Facilities

Charlene Harrington, James H. Swan, and Helen Carrillo

Objective. To examine the relationship between nursing staffing levels in U.S. nursing homes and state Medicaid reimbursement rates.

Data Sources. Facility staffing, characteristics, and case-mix data were from the federal On-Line Survey Certification and Reporting (OSCAR) system and other data were from public sources.

Study Design. Ordinary least squares and two-stage least squares regression analyses were used to separately examine the relationship between registered nurse (RN) and total nursing hours in all U.S. nursing homes in 2002, with two endogenous variables: Medicaid reimbursement rates and resident case mix.

Principal Findings. RN hours and total nursing hours were endogenous with Medicaid reimbursement rates and resident case mix. As expected, Medicaid nursing home reimbursement rates were positively related to both RN and total nursing hours. Resident case mix was a positive predictor of RN hours and a negative predictor of total nursing hours. Higher state minimum RN staffing standards was a positive predictor of RN and total nursing hours while for-profit facilities and the percent of Medicaid residents were negative predictors.

Conclusions. To increase staffing levels, average Medicaid reimbursement rates would need to be substantially increased while higher state minimum RN staffing standards is a stronger positive predictor of RN and total nursing hours.

Key Words. Nurse staffing, nursing facilities, Medicaid reimbursement, rates, resident case mix

Many studies have documented the importance of nursing staff in both the process and the outcomes of nursing home care (Aaronson, Zinn, and Rosko 1994; Bliesmer et al. 1998; Carter and Porell 2003; USCMS 2001; Grabowski 2001a, b; Harrington et al. 2000; Schnelle et al. 2004; Spector and Takada 1991; Zhang and Grabowski 2004). A recent study identified a threshold for registered nurses (RNs) and total nurse staffing levels (RNs, licensed vocational nurses [LVNs] and nursing assistants [NAs]) necessary to protect the

health and safety of residents (USCMS 2001). Over 90 percent of the nation's nursing homes had staffing levels below this level (USCMS 2001).

As the evidence accumulates about the importance of higher levels of staffing for improving the quality of nursing home care, the Institute of Medicine (IOM) (1996, 2001, 2003) called for increasing the federal regulatory requirements for nursing home staffing in three separate reports. In spite of these recommendations, total average nursing home staffing levels have remained relatively steady since 1994, although there was a 25 percent decline in RN staffing levels since passage of the Balanced Budget Act in 1997 (Harrington et al. 2003; Konetzka et al. 2004).

Nursing facilities (NFs) vary widely in the amount and type of nursing service they provide to residents (Zinn 1993a; IOM 1996, 2001; Harrington et al. 1998; 2000; 2003). The variation is based in part upon decisions that nursing facility managers/owners make about the amount and type of staff they want to provide. Some nursing facility owners and managers may make strategic decisions to provide higher levels of total staffing or more RN staff, even though this would increase facility costs, as a means of competing for residents or competing for the Medicare and private pay market (with higher reimbursement rates), and/or as a service to residents. Other NFs may target the Medicaid market (with lower reimbursement rates) in order to ensure a stable resident population. In this latter situation, facilities may elect to keep staffing levels low in order to keep expenditures under their Medicaid revenues (United States General Accounting Office [USGAO] 2000; USCMS and Scully 2003).

In 2002, Medicaid and other public payers paid for 51 percent of the nation's total $103 billion in nursing home expenditures, while Medicare paid for 12.5 percent, private insurance paid for 7 percent, and consumers paid the remaining costs (Levit et al. 2004). Because Medicaid pays for 67 percent of all nursing home residents in the United States (Harrington et al. 2003), the Medicaid reimbursement rates and methods are central to understanding nursing home staffing levels (IOM 2001). State cost containment efforts have resulted in substantially lower Medicaid reimbursement rates (an average of $115 per day across the nation in 2000) than Medicare rates ($269 for freestanding facilities in 2000) (USCMS and Scully 2003; USGAO 2000;

Address correspondence to Charlene Harrington, Ph.D., R.N., Department of Social & Behavioral Sciences, University of California, 3333 California Street, Suite 455, San Francisco, CA 94118. James H. Swan, Ph.D., is with the Department of Applied Gerontology, School of Community Service, Denton, TX. Helen Carrillo, M.S., is with the Department of Social & Behavioral Sciences, University of California, San Francisco, CA.

2002a, b). Low Medicaid reimbursement rates can result in low staffing and quality (Cohen and Dubay 1990; Zinn 1993b; Aaronson, Zinn, and Rosko 1994; Cohen and Spector 1996; Grabowski 2001a, b).

This study examined the relationship of nurse staffing and state Medicaid reimbursement rates in U.S. NFs in 2002, using nurse staffing data from the federal On-line Survey Certification and Reporting (OSCAR) system, in a two-stage regression model. Although previous studies have shown the relationship between Medicaid reimbursement rates and staffing, they have not taken into account the complex relationship of staffing with other factors (Cohen and Dubay 1990; Zinn 1993b; Aaronson, Zinn, and Rosko 1994; Cohen and Spector 1996; Grabowski 2001a, b). Building on the work of Harrington and Swan (2003) for California, this study specifically examined the relationship of RN (and total) staffing hours per resident day with two endogenous measures: (1) state Medicaid reimbursement rates and (2) facility resident case mix. The study should be useful to policy makers as they consider changes that would improve nurse staffing levels and quality of care.

Conceptual Model and Hypotheses

Resource dependency theory is used in this study to examine factors in the environment that influence organizational decisions (Thompson 1967; Pfeffer and Salancik 1978) of nursing homes. Nursing homes like other health care organizations depend upon resources in the environment and make accommodations with the environment to ensure their own survival (Banaszak-Holl et al. 1996; Scott 1998; Zinn, Weech, and Brannon 1998; Zinn et al. 1999). Facilities particularly depend on revenues from Medicaid and Medicare (Levit et al., 2004). Organizational characteristics are mediators of organizational decisions and impact on the ability of nursing homes to respond to contingencies (Banaszak-Holl et al. 1996; Zinn et al. 1999). The dependency on the economic environment is also related to political factors and regulatory requirements. In this study, nursing staffing levels (hours) are expected to be related to Medicaid nursing home rates and residents' need for care (case mix) as well as: sociodemographic and economic variables, political variables, and market factors.

Potentially Endogenous Variables

Nurse Staffing Hours per Resident Day

The dependent variable in the study was nurse staffing in NFs, using NFs as the unit of analysis. Two types of nurse staffing were considered in

separate models: (1) RN hours per resident day and (2) total nurse staffing hours per resident day (which includes RNs, LVN/LPNs, and NAs hours per resident day). RNs have the highest training requirements and are more expensive to employ than LVN/LPNs and NAs (AHCA, Decker et al. 2003). Higher RN and total staffing levels should increase state Medicaid reimbursement rates and encourage facilities to accept residents with higher case-mix levels. At the same time, facilities with higher Medicaid reimbursement rates and higher case-mix levels should have higher RN hours and total nursing hours.

State Medicaid Reimbursement Rates

Aaronson et al. (1994), Cohen and Spector (1996), Zinn (1993a, b), and Grabowski (2001a, b) found significant positive relationships between staffing and reimbursement. As Medicaid reimbursement rates are set by state policy makers, in part, on the basis of facility costs including staffing, higher staffing should result in higher Medicaid nursing homes reimbursement rates. Moreover, some states that have increased nursing home staffing requirements have increased Medicaid reimbursement rates to cover these costs (Tilly et al. 2003). Facilities that receive higher rates should be able to increase staffing levels making rates and staffing potentially endogenous.

Resident Case Mix

A number of nursing facility studies have shown a strong positive relationship between resident characteristics (case mix) and nurse staffing time (Cohen and Dubay 1990; Fries et al. 1994). Because residents with higher case-mix needs (where high values represent high acuity) require more nursing staff time to meet their needs, facilities should make decisions to increase their staffing hours when residents require additional time and/or expertise. Resident characteristics are expected to be endogenous with nurse staffing levels because facilities with higher staffing may choose to or may be more likely to admit residents with higher case mix (Harrington and Swan 2003).

Table 1 shows the specific hypothesized relationships among the potentially endogenous variables. The table also shows the factors used to identify RN hours and the total nursing hours in two separate equations using a two-stage model based upon existing literature. The shaded areas show where variables are omitted from the model in order to identify the endogenous variables.

Table 1: Hypotheses for Structural Model: Medicaid Rates, Case Mix, and Nursing Staffing

	State Medicaid Reimbursement Rates	*Resident Case Mix*	*RN Hours*	*Total Nursing Hours**
Endogenous variables				
State Medicaid reimbursement rate		+	+	+
Resident case mix	+		+	+
Total RN hours per resident day	+	+		
Total nursing hours per resident day	+	+		
Facility resources				
RN pay rate per hour	+	+	–	–
Proportion Medicaid residents	–	–	–	–
Medicaid case-mix reimbursement method		+	+	+
Prospective reimbursement method	–	–		
State RN minimum staffing standard	+		+	+
Medicare SNF reimbursement rate	+	+	+	+
Facility characteristics				
For-profit facility	–	–	–	–
Multifacility system member	–		–	–
Hospital-based		+	+	+
Number of facility beds	–		–	–
Facility dual/distinct part certification	+	+	+	+
Facility SNF certification	–	+	+	+
Demographic/economic variables (state)				
Proportion aged 65 and older	+	+	+	+
Percentage females in the labor force		+	+	+
Personal income per capita	+		+	+
Percent metropolitan population	+	–	+	+
Political variables				
Democratic governor	+			
Political party split	–	–	–	–
Market factors				
Nursing facility Herfindahl index (facility concentration)		–	–	–
Percent excess NF beds in the county	–	–	–	–
Nursing home beds per 1,000 aged 65+	–	–	–	–
Hospital beds per 1,000 population	–	–	–	–

Shaded areas show omitted variables from the model; + = positive predictor; – = negative predictor.
RN, registered nurse; SNF, skilled nursing care; NF, nursing facility.

EXOGENOUS VARIABLES

Nurse Pay Rates

RN pay rates are important market factors that impact nurse staffing levels in nursing homes. Where markets have higher RN pay rates, facilities are

expected to hire fewer RNs (and fewer hours) and perhaps substitute lower paid staff, such as LVNs and NAs for RNs, than in areas were RN pay rates are low (Zinn 1993b).

Facility Resources

NFs prefer the higher pay for Medicare and private pay residents over Medicaid residents (USGAO 2002b). Facilities in states with higher Medicare payment rates may have higher nurse staffing levels as well as higher Medicaid reimbursement rates and resident case mix. Higher percentages of Medicaid residents may result in facilities lowering their RN and total nurse staffing levels in order to keep costs under the state Medicaid reimbursement rates (Nyman 1988; Harrington et al. 1998; Zinn 1994). Staffing levels are not expected to have a direct effect on the percent of Medicaid residents in facilities (i.e., is not considered endogenous).

Medicaid case-mix reimbursement methods are increasingly used by states to give facilities higher reimbursement rates for higher case mix (Grabowski 2002; Swan et al. 2000). Facilities in states with case-mix reimbursement methods should increase their total nurse staffing hours because these states would pay higher rates tied to or adjusted for residents with higher care needs. At the same time, states that use prospective payment methods are expected to have lower Medicaid payment rates but this should not have a direct effect on nurse staffing levels.

Some states have established minimum staffing standards that go beyond the federal standards (Harrington 2005). It is expected that states that establish regulations with higher minimum standards for RN hours than the federal standards will have higher RN and total nurse staffing levels.

Facility Characteristics

Six facility characteristics were expected to be predictive of management decisions about nurse staffing levels. Lower overall staffing levels are expected in for-profit NFs (Cohen and Dubay 1990; Aaronson et al. 1994; Cohen and Spector 1996; Harrington et al. 1998). Chain-owned NFs have reported lower costs (Cohen and Dubay 1990), but these were not found to be due to reduced staffing levels (Cohen and Dubay 1990). Hospital-based NFs have traditionally had substantially higher nurse staffing levels because their residents have more Medicare residents, higher acuity levels, and require short-term intensive care (Cohen and Spector 1996; Harrington et al. 1998). Large facilities have been reported to be associated with higher quality (Nyman 1988) but other studies

found a negative relationship between size and staffing (Cohen and Spector 1996). Larger NFs are not required by federal law to have proportionate staffing and they may achieve some economies of scale in caring for residents.

Finally, facilities have the option of being certified for: (1) skilled nursing care (SNF) for Medicare-only; (2) NFs for Medicaid residents only; or (3) combination facilities (dually certified for Medicare and Medicaid or distinct-part facilities with a Medicare certified unit), if they meet the federal quality standards. NFs tend to make decisions to specialize in different markets based upon their payment sources (Zinn et al. 1999; Aaronson et al. 1994). Facilities certified for Medicare-only or dually certified or with a distinct-part unit should have more short-term residents with higher care needs and are expected to have higher staffing than Medicaid-only facilities.

Sociodemographic and Economic Variables

Higher percentages of the aged 65 and older population in a state were expected to have a positive effect on Medicaid reimbursement rates, resident case mix, and RN staffing hours (Kemper and Murtaugh 1991). The number of women in the labor force may increase resident case mix and increase the amount of RN hours. Facilities in states with higher state personal income should have higher Medicaid reimbursement rates and nurse staffing hours because more discretionary resources are available. The percent of a state's population living in metropolitan areas is expected to increase the state Medicaid rate and RN hours but decrease the resident case mix.

State Political Variables

States that have Democratic governors (often considered to be more liberal than Republicans) may be more generous in their financial support for Medicaid reimbursement rates (Lanning, Morrisey, and Ohsfeldt 1991) but this is not expected to be directly related to nurse staffing levels. In states where the party control of the House and the Senate are split, there may be less consensus and ability to provide consistent resources for state Medicaid programs and nurse staffing hours (Lanning et al. 1991).

Market Variables

NFs in areas with less nursing home bed competition (i.e., a higher concentration of beds using the Herfindal measure) are expected to have less RN hours and residents with lower case mix. Facilities in counties with a higher percentage of excess nursing home beds should have lower reimbursement

rates, resident case mix, and RN staffing hours. States with more nursing facility beds per population available should have more competition for nursing hours and therefore they would have fewer RN hours as well as lower reimbursement rates and lower case mix. Finally, hospital beds per population should be negatively associated with Medicaid nursing home reimbursement rates, resident case mix, and RN hours.

METHODS

Data Sources

All federally certified facilities for Medicare (skilled nursing care) and Medicaid (NFs) in 2002 were included in this study, except those located in the trust territories and Puerto Rico. The federal On-Line Survey Certification and Reporting system (OSCAR) was used for: (1) nurse staffing, (2) resident characteristics, and (3) facility characteristics (USCMS 2003). The OSCAR data require cleaning to correct some problems by eliminating duplicate provider records (191 facilities) and setting the maximum number of beds for a hospital-based facility to equal the maximum number of certified skilled nursing beds in the facility.

The average nursing hours per resident day (including all fulltime, part-time, and contract staff) were used to standardize the data. To make this conversion, the total nurse staff fulltime equivalents (FTEs) reported for a 2-week period were multiplied by 70 hours for the period and divided by the total number of residents and then divided by 14 days in the reporting period (the standard procedure used by CMS) for each type of nursing staff. RN directors of nursing and other RN administrators were included in the total RNs (about 0.08 hour per resident per day in a 100 bed facility).

In order to minimize erroneous data, standard procedures were used to remove outliers from the data set (Grabowski 2001a, b; Harrington et al. 1998; USCMS 2001). Facilities with 15 beds or less were excluded (398 facilities), facilities reporting more than 24 hours of staffing care per resident day, facilities with no hours or residents reported (54 facilities), and facilities in the upper 2 percent and lower 1 percent within each staffing category because they were outliers and appeared to be erroneous. We conducted a sensitivity analysis on alternative cuts for the removal of outliers (e.g., 1 standard deviation and the upper 1 percent) and found the regressions were comparable for different processes used (see also Harrington et al. 2000). As a result of the cleaning process, a total of 14,256 NFs were used in the RN analysis and 13,632 facilities were used for the total nurse staffing hours analysis, where more outliers were removed from total facilities.

Variable Definitions and Sources of Data

Table 2 shows the source for all the variables in the model as well as the means and standard deviations. For the Medicaid reimbursement rate, we used the

Table 2: Means and Standard Deviations for Study Variables (N= 14,256 Facilities)

	Data Source	*Mean*	*Std. Dev.*
Potentially endogenous variables			
State average Medicaid reimbursement rate, 2002	Swan (2003)	117.16	23.08
Resident case mix (ADL score) by facility, 2002	Harrington et al. (2003)	5.82	0.68
RN hours per resident day by facility, 2002	Harrington et al. (2003)	0.66	0.68
Total nursing hours per resident day by facility, 2002	Harrington et al. (2003)	3.62	1.17
Exogenous variables			
Facility resources			
RN pay rate per hour, 2002	BOL (2003b)	$22.80	$2.69
Percent Medicaid residents, 2002	Harrington et al. (2003)	63.09	23.98
Medicaid case-mix reimbursement (percent yes), 2002	Swan (2003)	69.19	
Medicaid prospective reimbursement method (percent yes), 2002	Swan (2003)	33.43	
State RN minimum staffing standard (hours per resident day), 2001	Harrington et al. (2005)	0.42	0.18
Medicare SNF reimbursement rate, 2001 adjusted to 2003 dollars	CMS (2003)	$273.01	$29.48
Facility characteristics			
For-profit facility (percent yes), 2002	Harrington et al. (2003)	66.10	
Multifacility system member (percent yes), 2002	Harrington et al. (2003)	52.47	
Hospital-based (percent yes), 2002	Harrington et al. (2003)	9.78	
Number of facility beds, 2002	Harrington et al. (2003)	105.91	66.42
SNF/NF dual and distinct (percent yes), 2002	Harrington et al. (2003)	84.41	
SNF (percent yes), 2002	Harrington et al. (2003)	5.48	
Demographic/economic variables (state level)			
Percent of population aged 65 and older, 2002	US BOC (2002)	12.62	1.80
Percent females in the labor force, 2002	US BOLS (2003a)	56.97	4.06
Personal income per capita, 2002	US DOC (2002)	$30,557	$4,097
Percent metropolitan population, 2001	US BOC (2002)	75.89	17.50
State political variables			
Democratic governor (percent yes), 2002	NCSL (2002a)	54.35	49.81
Political party split (percent yes), 2002	NCSL (2002b)	31.20	46.33
Market factors			
Nursing facility Herfindahl index in county, 2002	Harrington et al. (2003)	0.20	0.23
Percent excess NF beds in county, 2002	Harrington et al. (2003)	14.88	8.12
Nursing home beds per 1,000 aged +65, 2002	Harrington et al. (2004)	49.03	13.36
Hospital beds per 1,000 population, 2001	USDHHS (2003)	3.27	2.59

RN, registered nurse; SNF, skilled nursing care; NF, nursing facility; ADL, activities of daily living.

average payment rate for all NFs in the state (Swan 2003). For the RN pay rate, we used the state average rate (U.S. Bureau of Labor Statistics 2003b). The state minimum RN staffing standards (in hours per resident day) were available from a study by Harrington (2005). For the Medicare SNF reimbursement rates, we used the average state rate reported by CMS (USCMS and Scully 2003).

For the case-mix measure, OSCAR data were used to describe resident dependency on activities of daily living (ADL) in each facility. The average score for each of the three ADLs were used in this study: (1) eating, (2) toileting, and (3) transferring to and from the bed, chair, wheelchair, or a standing position. The OSCAR report has a three-point scale for each of these three categories, where a 1 indicates the lowest need for assistance and the 3 indicates the greatest need for assistance (highest case mix). The average summary score for each ADL was computed for each facility (range 1–3) and these were added together for a total score of 3–9 for the three ADL scores. ADL scores may be less likely to be manipulated by the facility to obtain higher reimbursement than resource utilization group (RUGs) scores (not available for the study) and have been used in other studies (Grabowski 2001a, b; Harrington and Swan 2003). We developed an alternative case-mix measure that summarized the total percentage of residents in a facility that needed intravenous therapy, injections, respiratory therapy, and ventilator therapy. No substantial differences were found when this summary case-mix score was used compared with the ADL dependency score.

The Herfindal score was calculated for each county using the total nursing home beds for each county for 2002 from the OSCAR data. The total beds in each NF were divided by the total beds in each county and then the proportions for each facility were squared and summed to create an index for each county. The index ranges from 0 to 1 with the higher values representing more concentration (less competition). Using OSCAR data, the percent of excess beds in each county was calculated by first subtracting the number of residents from the total number of beds to identify the vacant beds for each facility. Then, total vacant beds in each county were divided by the total number of beds in the county in order to identify the percent of vacant (excess) beds.

ANALYTICAL MODEL

The descriptive data for staffing levels were examined by facility characteristics and other independent variables. Two models were analyzed separately: (1) RN hours and (2) total nursing hours. Table 1 shows the specific hypothesized relationships between resident characteristics and nurse staffing levels and shows the instrumental variables used to identify each separate equation in

each of the two models, where the shaded areas show the omitted variables. Two instrumental variables were selected to predict RN hours and total nursing hours: (1) prospective reimbursement methods; and (2) democratic governor. These were selected because previous studies did not show that they would have a direct effect on RN hours or total nursing hours whereas they were expected to predict the potentially endogenous variables as discussed above.

Pearson correlations among the predictor variables were modest, suggesting that multicollinearity was not likely to be problematic. Tolerance statistics were also used in the regression analysis; they did not detect a high degree of multicollinearity among the variables. We examined the relationship between state Medicaid levels and facility staffing levels using a χ^2 analysis.

There was also a concern that there may be correlated errors among endogenous variables if an ordinary least squares (OLS) model was used. In this situation, if the correlation between the endogenous variables with the "error terms" for the staff hours is positive, then the OLS estimator may be biased upward or if it is negative, it could be biased downward. Because of this concern, we conducted both the OLS regression and a two-stage least squares (2SLS)[1] regression analysis to assess the relationships among the potentially endogenous variables. We calculated the Durbin–Wu–Hausman test for endogeneity and report the results in the findings section (Davidson and MacKinnon 1993). There was a concern regarding whether RN pay rates were endogenous but the Hausman test confirmed that RN pay was not endogenous in the RN and total nursing hour models.

The study used the *Stata*, version 8 for the OLS and the 2SLS regression analysis. See the footnote for the equations used. First-stage (reduced-form) and second-stage equations were estimated for the endogenous variables. In the first stage, each endogenous variable was regressed (using OLS regression analysis) on all exogenous factors (shown in Table 3), and the predicted values for each endogenous factor were retained for the second stage. The first stage regression models showed that the R^2 values are sufficiently high.

Table 3 shows the first stage regression for RN hours with and without the instrumental variables. Exclusions tests were performed to verify that the instruments predicted the endogenous variables and not the staffing variables. A comparison of the R^2 was performed and joint F tests were calculated (Wooldridge 2003). These tests showed that the instrumental variables were not predictors of RN hours or total nursing hours and that the instrumental variables appeared to meet the requirements to estimate the second stage.

An overidentification test for the instrumental variables was conducted by regressing the 2SLS equation residuals on the exogenous variables and then

Table 3: Stage 1—OLS Reduced-Form Equations: Medicaid Rates, Resident Case Mix, RN Hours, and Total Nursing Hours (Coefficients with Standard Error in Parentheses)

Exogenous Factors	*State Average Medicaid Reimbursement Rate*	*Resident Case Mix*	*RN Hours*	*Total Nursing Hours*	*RN Hours without Instrumental Variables***	*Total Hours without Instrumental Variables****
Facility resources						
RN pay rate per hour	5.890**	0.055**	0.001	0.039**	−0.003	0.053**
	(0.101)	(0.006)	(0.004)	(0.008)	(0.004)	(0.008)
Proportion Medicaid	0.014*	−0.0002	−0.003**	−0.005**	−0.003**	−0.005**
residents	(0.005)	(0.0003)	(0.0002)	(0.0004)	(0.0002)	(0.0004)
Medicaid case-mix	3.932**	0.008	0.016	−0.150**	0.008	−0.134**
reimbursement	(0.261)	(0.015)	(0.011)	(0.021)	(0.010)	(0.020)
Medicaid prospective	−15.936**	−0.060**	−0.044**	−0.110**		
reimbursement method	(0.251)	(0.014)	(0.010)	(0.020)		
State RN minimum	28.978**	0.111**	0.247**	0.562**	0.232**	0.703**
Staffing standard	(0.726)	(0.041)	(0.029)	(0.057)	(0.028)	(0.054)
Medicare SNF	−0.105**	−0.007**	0.001*	−0.002**	0.001**	−0.005**
Reimbursement rate	(0.009)	(0.001)	(0.0004)	(0.001)	(0.0003)	(0.001)
Facility characteristics						
For-profit facility	−1.588**	−0.067**	−0.147**	−0.358**	−0.148**	−0.359**
	(0.219)	(0.012)	(0.009)	(0.017)	(0.009)	(0.017)
Multifacility system	−1.714**	−0.005	−0.008	−0.132**	−0.007	−0.134**
Member	(0.198)	(0.011)	(0.008)	(0.016)	(0.008)	(0.016)
Hospital-based	0.186	0.010	0.024	0.054*	0.024	0.058*
	(0.316)	(0.018)	(0.013)	(0.025)	(0.013)	(0.025)
Number of facility beds	0.010**	0.0001	−0.001**	−0.001**	−0.001**	−0.001**
	(0.002)	(0.0001)	(0.0001)	(0.0001)	(0.0001)	(0.0001)
Dual/distinct part	1.917**	0.266**	0.099**	0.201**	0.100**	0.219**
Certification	(0.332)	(0.019)	(0.014)	(0.026)	(0.013)	(0.027)

SNF certification	0.158*	−0.080*	1.937**	2.911**	1.939**	2.927**
	(0.627)	(0.035)	(0.025)	(0.050)	(0.025)	(0.050)
County demographic economic variables						
Proportion aged 65 and older	2.941**	−0.038**	0.002	0.024**	0.006*	0.020**
	(0.070)	(0.004)	(0.003)	(0.006)	(0.003)	(0.005)
Percentage females in labor	−0.682**	−0.014**	−0.001	−0.007**	−0.0002	−0.003
force	(0.035)	(0.002)	(0.001)	(0.003)	(0.001)	(0.003)
Personal income per capita	1.661**	−0.009**	0.015**	−0.002	0.017**	−0.001
	(0.053)	(0.003)	(0.002)	(0.004)	(0.002)	(0.004)
Percent metropolitan	−0.338**	0.003**	−0.003**	−0.005**	−0.004**	−0.003**
Population	(0.012)	(0.001)	(0.001)	(0.001)	(0.001)	(0.001)
Political variables						
Democratic governor	−6.647**	0.085**	0.025**	−0.129**		
	(0.235)	(0.013)	(0.010)	(0.018)		
Political party split	−4.455**	−0.200**	0.022*	0.050*	0.021*	−0.018
	(0.270)	(0.015)	(0.011)	(0.021)	(0.010)	(0.020)
Market factors						
NF Herfindahl (facility	0.279	−0.134**	−0.045*	−0.059	−0.042*	−0.051
concentration)	(0.469)	(0.026)	(0.019)	(0.037)	(0.019)	(0.037)
Percent excess NF beds in the	−0.062**	−0.003**	0.001	0.007**	0.001	0.006**
county	(0.014)	(0.001)	(0.001)	(0.001)	(0.001)	(0.001)
Nursing home beds per 1,000	−0.094**	−0.011**	−0.002**	−0.014**	−0.003**	−0.014**
age 65+	(0.011)	(0.001)	(0.0004)	(0.001)	(0.0004)	(0.001)
Hospital beds per 1,000	−0.037	0.0001	0.002	0.007*	0.001	0.008**
population	(0.038)	(0.002)	(0.002)	(0.003)	(0.002)	(0.003)
Intercept	−12.609**	8.249**	0.340**	4.699**	0.363**	4.804**
	(2.561)	(0.144)	(0.104)	(0.202)	(0.104)	(0.202)

Continued

Table 3. *Continued*

Exogenous Factors	*State Average Medicaid Reimbursement Rate*	*Resident Case Mix*	*RN Hours*	*Total Nursing Hours*	*RN Hours without Instrumental Variables***	*Total Hours without Instrumental Variables***
R^2	0.771**	0.162**	0.560**	0.477**	0.559**	0.474**
Mean =	117.16	5.82	0.66	3.62	0.66	3.62
N = 14,256; df =	22	22	22	22	20	20

Shaded areas show omitted variables from the model.

*Significant at the .05 level.

**Significant at the .01 level.

***Instrumental variables are excluded from the OLS regression.

RN, registered nurse; SNF, skilled nursing care; NF, nursing facility.

multiplying the R^2 by the sample size (nR^2). The resulting nR^2 showed that the IV's were uncorrelated with the residuals and the values were small (nR^2 for the RN Hours Model was 0.570 and 0.545 for the total hours; p-value = .53 for both). Therefore, the variables passed the overidentification test (Wooldridge 2003). The first-stage equations for total nursing hours were estimated but are not reported here (a table of such results will be furnished upon request).

In the second stage, each endogenous factor was regressed, based on the specified structural model, on: (1) the predicted values of the other endogenous factors from the first stage and (2) the exogenous factors. In order to take into account the potential clustering of state variables in the regressions, we used the *Stata* jackknife cluster procedures to test state level effects. No significant difference was found between the 2SLS estimates and the jackknife cluster estimates using t-tests. We also conducted the regression analysis to calculate robust standard errors.

RESULTS

Staffing Levels

The average hours of RN (including nurse administrators) care were 0.66 hours (40 minutes) per resident day and total nurse staffing hours per resident day averaged 3.62 hours per resident day in 2002. The average Medicaid reimbursement rate was $117 per day but rates ranged from $80 to $200 per day. A significant relationship between higher RN and total nursing hours and higher state Medicaid reimbursement rates was found using a χ^2 test (no table shown).

RN Hours

The 2SLS model found that the expected variables were endogenous using the Hausman test for endogeneity. (See Table 4 for the OLS and the 2SLS regression results for RN hours.) Therefore, 2SLS was the most appropriate model for RN hours. RN hours were positively related to the state Medicaid reimbursement rate as expected. A $10 increase in state Medicaid reimbursement rates would increase RN hours by an estimated 0.01 hours per resident day or 1 hour for every 100 residents. Resident case mix was positively related to RN hours as expected.

As expected, RN pay reduced the number of RN hours of care. The proportion of Medicaid residents in a facility was a negative predictor of RN hours as expected. A ten percent decrease in Medicaid residents increased total RN staff by 0.03 hours per resident day or 3 hours for every 100 residents per day. Facilities in states that had case-mix reimbursement did not have

Table 4: Stage Two Analysis and Ordinary Least Square Analysis: RN Hours and Total Nursing Hours (Coefficients with Robust Standard Errors in Parentheses)

	RN Nursing Hours OLS Regression	*RN Nursing Hours 2SLS*†	*Total Nursing Hours OLS Regression*	*Total Nursing Hours 2SLS*†
Potentially endogenous variables				
State Medicaid reimbursement rate	0.002**	0.001*	0.006**	0.010**
	(0.0003)	(0.001)	(0.001)	(0.001)
Resident case mix (ADL dependency)	0.020*	0.392**	0.175**	−0.821**
	(0.008)	(0.107)	(0.015)	(0.233)
Exogenous variables				
Facility resources				
RN pay rate per hour	−0.014**	−0.029**	0.006	0.028
	(0.004)	(0.007)	(0.008)	(0.016)
Proportion Medicaid residents	−0.003**	−0.003**	−0.005**	−0.006**
	(0.0002)	(0.0002)	(0.0004)	(0.001)
Medicaid case-mix reimbursement	0.002	0.008	−0.163**	−0.177**
	(0.011)	(0.012)	(0.021)	(0.026)
Medicaid prospective reimbursement method				
State RN staffing standard	0.169**	0.166**	0.479**	0.388**
	(0.032)	(0.040)	(0.062)	(0.083)
Medicare SNF reimbursement rate	0.002**	0.004**	−0.002**	−0.007**
	(0.0003)	(0.001)	(0.001)	(0.002)
Facility characteristics				
For-profit facility	−0.143**	−0.118**	−0.343**	−0.376**
	(0.009)	(0.012)	(0.018)	(0.024)
Multifacility system member	−0.005	−0.004	−0.124**	−0.119**
	(0.008)	(0.009)	(0.016)	(0.019)
Hospital-based	0.023	0.019	0.056	0.059
	(0.016)	(0.017)	(0.030)	(0.036)

Number of facility beds	−0.001**	−0.001**	−0.001**	−0.001**
	(0.0001)	(0.0001)	(0.0001)	(0.0002)
Dual/distinct part certification	0.089**	−0.008	0.158**	0.381**
	(0.010)	(0.031)	(0.022)	(0.065)
SNF certification	1.935**	1.966**	2.926**	2.817**
	(0.059)	(0.063)	(0.101)	(0.112)
County demographic/economic variables demographic/economic variables				
Proportion aged 65 and older	0.001	0.013*	0.006	−0.035**
	(0.003)	(0.005)	(0.006)	(0.011)
Percentage females in labor force	0.001	0.006**	0.002	−0.014**
	(0.002)	(0.002)	(0.003)	(0.005)
Personal income per capita	0.014**	0.016**	−0.012**	0.024**
	(0.002)	(0.003)	(0.004)	(0.006)
Percent metropolitan population	−0.003**	−0.004**	−0.002*	0.001
	(0.001)	(0.001)	(0.001)	(0.001)
Political variables				
Democratic governor				
Political party split	0.042**	0.106**	0.071**	−0.053
	(0.011)	(0.023)	(0.021)	(0.047)
Market factors				
NF Herfindahl index (facility concentration)	−0.042**	0.007	−0.038	−0.144**
	(0.015)	(0.023)	(0.032)	(0.048)
Percent excess NF beds in the county	0.001	0.002**	0.008**	0.005**
	(0.001)	(0.001)	(0.001)	(0.002)
Nursing home beds per 1,000 aged 65+	−0.002**	0.002	−0.011**	−0.022**
	(0.0004)	(0.001)	(0.001)	(0.003)
Hospital beds per 1,000 population	0.001	0.002	0.008**	0.007*
	(0.001)	(0.002)	(0.003)	(0.003)

Continued

Table 4. *Continued*

	RN Nursing Hours OLS Regression	*RN Nursing Hours 2SLS*†	*Total Nursing Hours OLS Regression*	*Total Nursing Hours 2SLS*†
Intercept	0.195	−2.88**	3.355**	11.700**
	(0.125)	(0.892)	(0.235)	(1.984)
R^2	0.560**	0.443**	0.486**	0.229**
Mean =	0.66	0.66	3.62	3.62
N = 14,256; df =	22	22	22	22

*Significant at the .05 level.

**Significant at the .01 level.

†Because reimbursement rates and ADL were endogenous, the 2SLS model was the most appropriate.

The shaded areas show instrumental variables that predict endogenous variables but that do not predict RN hours and total nursing hours.

RN, registered nurse; SNF, skilled nursing care; NF, nursing facility; OLS, ordinary least squares; 2SLS, two-stage least square; ADL, activities of daily living.

higher RN hours but facilities in states with higher minimum standards for RN hours did have higher actual RN hours per resident day (an increase of 16.6 RN hours for every 100 residents which is a substantial difference).

For-profit facilities had fewer RN hours (0.12 hours less per resident day or 12 hours less care for 100 residents) than nonprofit and government facilities. Smaller facilities and SNF-certified beds (compared with Medicaid-only facilities) had higher levels of RN nurse staffing.

Facilities in states with higher percentages of aged, more females in the labor force, with higher average incomes, and a party split in the state legislature had higher RN staffing hours. States with more metropolitan areas had fewer RN hours, controlling for other factors. Market factors were not as important as expected. Only areas where there was an excess of nursing home beds per county had more RN hours of care.

Total Nursing Hours

Table 4 also shows the OLS and 2SLS model for total nursing hours. As expected state Medicaid reimbursement rates and resident case mix were both found to be endogenous using the Hausman test for endogeneity so that the 2SLS model was the most appropriate model. The analysis found that an increase in state Medicaid reimbursement rates of $10 per resident day would increase total nurse staffing by 0.10 hours per resident or 10 hours per 100 residents. Contrary to expectations, resident case mix was negatively associated with total nursing hours.

RN pay rates were not related to total nursing hours. Other findings for total nursing hours were similar to the RN model, except that Medicaid case-mix reimbursement was a negative predictor of total hours. Total nurse staffing hours were also substantially higher in states that had higher minimum RN staffing standards. Overall, the 2SLS models explained 44.3 percent of the variance for RNs hours and explained 22.9 percent for the total nursing staff hours (Table 4). Both models showed that the relationship between staffing and Medicaid reimbursement rates was positive but not as strong as the relationship with state minimum staffing standards.

DISCUSSION

As expected, a small, positive relationship between state Medicaid reimbursement rates was found for both RN and total nurse staffing hours per resident day. This is consistent with other studies that have found that higher

Medicaid reimbursement rates encourage facilities to provide more nursing care (Cohen and Dubay 1990; Zinn 1993b; Aaronson et al. 1994; Cohen and Spector 1996; Grabowski 2001a, b). The major difference between this study and previous studies is that we developed a conservative model to account for potential endogeneity and we included a comprehensive set of potential predictive factors including nursing home staffing standards, Medicare reimbursement rates, and many other factors.

The actual average RN staffing (0.66) in the U.S. NFs found in this study was 0.09 hours lower than 0.75 RN hours per resident day and the actual average total nurse staffing (3.62) was 0.5 hours per resident day lower than the 4.1 hours found to be necessary to prevent harm or jeopardy to residents with long stays in the study prepared for CMS (USCMS 2001). Using a simple linear extrapolation, a crude estimate was made that in order to increase RN staffing by 0.09 hours per resident day to the recommended level, Medicaid would need to increase its rates by $90 per resident per day, holding other factors constant. In order to increase total nurse staffing levels by 0.5 hours per resident day as recommended, Medicaid reimbursement rates would need to be increased by $50 per resident per day.

The case mix of residents was a positive predictor of RN hours and was a negative predictor of total staffing hours, suggesting that NFs take resident case mix into account for RNs but not for total nurse staffing levels, which could result in inadequate total hours for residents with high care needs. Higher RN pay rates per hour were related to lower RN hours as found in another study (Zinn 1993b), but not to total nurse staffing hours.

As expected, higher percentages of Medicaid residents had a negative effect on RN and total staffing levels, controlling for Medicaid reimbursement rates and other factors. Facilities that are more resource dependent upon Medicaid reimbursement appear to be reluctant to hire more staff of all types. The findings are consistent with previous findings by Nyman (1988), Harrington et al. (1998), and Grabowski (2001a, b) where facilities with higher proportions of Medicaid residents had fewer nurses and consequently these facilities appeared to have lower quality of care (Mor et al. 2004). This effect is troubling from a policy perspective, because Medicaid residents should receive the same staffing levels that other residents receive.

NFs that are heavily dependent on Medicaid payments can be expected to keep staffing at the existing levels unless Medicaid rates are raised or other policies are changed such as instituting minimum staffing requirements, recommended by the IOM (2003). If the goal is to increase nurse staffing levels using a market-incentive approach, state Medicaid reimbursement rates need

to be substantially increased. States are unlikely to raise their Medicaid rates by the amount needed to encourage or require facilities to implement the recommended nurse staffing levels without some federal financial incentives beyond the current federal–state Medicaid matching formula. Another potential policy approach is to use nurse staffing levels as a pay-for-performance indicator in the current federal demonstration projects that are considering pay-for-performance indicators. In order to make this possible, an increase in nurse staffing costs would probably need to be offset by a reduction in hospitalization and other costs in order to maintain some cost neutrality.

A more successful, but politically charged, approach appears to be instituting higher state minimum RN staffing standards, because states with higher minimum RN staffing standards were shown to have substantially higher RN and total nurse staffing levels in this study. In any case, these findings show the need for further consideration of both minimum staffing levels and Medicaid reimbursement rates by public policy makers at the state and federal levels.

ACKNOWLEDGMENT

We would like to thank the reviewers for their excellent suggestions and Professor Dana Mukamel for her comments and recommendations and Joseph Mullan, Ph.D., at UCSF for his assistance.

NOTE

1. In this 2SLS model, the following equations were examined:

$$\text{Nurse staff}_i = a + \text{Medicaid rate}^* + \text{Case mix}^* + X_i + E_i \quad (1a)$$

$$\text{Medicaid rate}_i = a' + \text{Nurse staff}_i^* + \text{Case mix}_i^* + Y_i + e_i \quad (1b)$$

$$\text{Case mix}_i = a' + \text{Medicaid rate}_i^* + \text{Nurse staff}_i^* + Y_i + e_i \quad (1c)$$

where i is the facility; Nurse staff$_i$ the average nursing hours per resident day for different types of staff in nursing facilities; Nurse Staff$_i^*$ an instrumental variable estimated using all exogenous variables which represents the estimated staffing level for nurses in each nursing facility; Medicaid rate$_i$ the average nursing home Medicaid rate; Medicaid rate$_i^*$ an instrumental variable estimated using all exogenous variables which represents the estimated average Medicaid Rate for nursing facility

residents; Case mix_i the average resident score for eating, toileting, and transferring for each nursing facility; Case mix_i^* an instrumental variable estimated using all exogenous variables which represents the estimated average case-mix index for each nursing facility; X_i the facility resources, facility characteristics, socioeconomic variables, policy variables, and market variables that were considered to influence the supply and demand for nursing staff levels in nursing facilities; Y_i the facility resources, facility characteristics, socioeconomic variables, and policy variables that were considered to influence the average Medicaid rate and resident case mix; E_i, e_i are the random error terms.

REFERENCES

Aaronson, W. E., J. S. Zinn, and M. D. Rosko. 1994. "Do For-Profit and Not-for-Profit Nursing Facilities Behave Differently?" *Gerontologist* 34 (6): 775–86.

American Health Care Association (AHCA), Decker, F. H., P. Gruhn, L. Matthews-Martin, K.J. Dollard, A.M. Tucker, and L. Bizette. 2003. *Results of the 2002 AHCA Survey of Nursing Staff Vacancy and Turnover in Nursing Homes.* Washington, DC: AHCA.

Banaczak-Holl, J., J. S. Zinn, and V. Mor. 1996. "The Impact of Market and Organizational Characteristics on Nursing Care Facility Innovation: A Resource Dependency Perspective." *Health Services Research* 31 (1): 97–118.

Bliesmer, M. M., M. Smayling, R. Kane, and I. Shannon. 1998. "The Relationship between Nursing Staffing Levels and Nursing Home Outcomes." *Journal of Aging and Health* 10 (3): 351–71.

Carter, M. W., and F. W. Porell. 2003. "Variations in Hospitalization Rates among Nursing Home Residents: The Role of Facility and Market Attributes." *Gerontologist* 43 (2): 175–91.

Cohen, J. W., and L. C. Dubay. 1990. "The Effects of Medicaid Reimbursement Method and Ownership on Nursing Home Costs, Case Mix and Staffing." *Inquiry* 27: 183–200.

Cohen, J. W., and W. D. Spector. 1996. "The Effect of Medicaid Reimbursement on Quality of Care in Nursing Facilities." *Journal of Health Economics* 15: 23–8.

Davidson, R., and J. G. MacKinnon. 1993. *Estimate and Inference in Econometrics.* New York: Oxford University Press.

Fries, B. E., D. Schneider, W. Foley, M. Gavazzi, R. Burke, and E. Cornelius. 1994. "Refining a Case-Mix Measure for Nursing Facilities: Resources Utilization Groups (RUGS-III)." *Medical Care* 32 (7): 668–85.

Grabowski, D. C. 2001a. "Does an Increase in the Medicaid Reimbursement Rate Improve Nursing Home Quality?" *Journal of Gerontology: Social Sciences* 56B (2): S84–93.

———. 2001b. "Medicaid Reimbursement and the Quality of Nursing Home Care." *Journal of Health Economics* 20: 549–69.

———. 2002. "The Economic Implications of Case-Mix Medicaid Reimbursement for Nursing Home Care." *Inquiry* 39 (3): 258–78.

Harrington, C. 2005. "Nurse Staffing in Nursing Homes in the United States. Part II." *Journal of Gerontological Nursing* 31 (3): 9–15.

Harrington, C., H. Carrillo, J. Mullan, and J. H. Swan. 1998. "Nursing Facility Staffing in the States in the 1991–95 Period." *Medical Care Research and Review* 55 (3): 334–63.

Harrington, C., H. Carrillo, V. Wellin., and A. Burdin. 2003. *Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1996–02.* San Francisco: University of California (www.nccnhr.org).

Harrington, C., S. Chapman, E. Miller, R. Newcomer, and N. Miller. 2004. *Trends in the Supply of Long Term Care Beds in the U.S. Journal Health and Social Policy* 19 (2): 31–58.

Harrington, C., and J. H. Swan. 2003. "Nurse Home Staffing, Turnover, and Casemix." *Medical Care Research and Review* 60 (2): 366–92.

Harrington, C., D. Zimmerman, S. L. Karon, J. Robinson, and P. Beutel. 2000. "Nursing Home Staffing and Its Relationship to Deficiencies." *Journal of Gerontology: Social Sciences* 55B (5): S278–287.

Institute of Medicine (IOM). 1996. *Nursing Staff in Hospitals and Nursing Facilities: Is It Adequate?* Committee on the Adequacy of Nurse Staffing in Hospitals and Nursing Facilities, Summary. Washington, DC: National Academy Press.

———. 2001. In *Improving the Quality of Long-Term Care*, edited by G. S. Wunderlich, and P. Kohler, Summary. Washington, DC: National Academy of Sciences.

———. 2003. In *Keeping Patients Safe*, edited by A. Page, Summary. Washington, DC: National Academy of Sciences.

Kemper, P., and C. M. Murtaugh. 1991. "Lifetime Use of Nursing Home Care." *New England Journal of Medicine* 324 (9): 595–600.

Konetzka, R. T., D. Yi, E. C. Norton, and K. E. Kilpatrick. 2004. "Effects of Medicare Payment Changes on Nursing Home Staffing and Deficiencies." *Health Services Research* 39 (3): 463–87.

Lanning, J. A., M. A. Morrisey, and R. L. Ohsfeldt. 1991. "Endogenous Hospital Regulation and Its Effects on Hospital and Non-Hospital Expenditures." *Journal of Regulatory Economics* 3: 137–54.

Levit, K., C. Smith, C. Cowan, H. Lazenby, A. Sensenig, A. Catlin, and the Health Accounts Team. 2004. "Health Spending Rebound Continues in 2002." *Health Affairs* 23 (1): 147–59.

Mor, V., J. Zinn, J. Angelelli, J. M. Teno, and S. C. Miller. 2004. "Driven to Tiers: Socioeconomic and Racial Disparities in the Quality of Nursing Home Care." *Milbank Quarterly* 82 (2): 227–56.

National Conference of State Legislatures (NCSL). 2002a. *2002 Post-Election Party of State Governors. State Vote 2002.* Washington, DC: NCSL [accessed July 2003]. Available at www.ncsl.org/statevote2002/govParty_post2002./htm

———. 2002b. *Fifty-State Party Composition Table Pre-Election Partisan Composition of State Legislatures. State Vote 2002.* Washington, DC: NCSL [accessed July 2003]. Available at www.ncsl.org/ncsidb/elect98/partcomp.cfm?yeasel=2002

Nyman, J. A. 1988. "Improving the Quality of Nursing Home Outcomes: Are Adequacy- or Incentive-Oriented Policies More Effective?" *Medical Care* 26 (12): 1158–71.

Pfeffer, J., and G. R. Salancik. 1978. *The External Control of Organizations.* New York: Harper & Row.

Schnelle, J. F., S. F. Simmons, C. Harrington, M. Cadogan, E. Garcia, and B. Bates-Jensen. 2004. "Relationship of Nursing Home Staffing to Quality of Care?" *Health Services Research* 39 (2): 225–50.

Scott, W. R. 1998. *Organizations: Rational, Natural, and Open Systems.* 4th Edition. Upper Saddle River, NJ: Prentice Hall.

Spector, W. D., and H. A. Takada. 1991. "Characteristics of Nursing Facilities That Affect Resident Outcomes." *Journal of Aging and Health* 3 (4): 427–54.

Swan, J. H. 2003. *State Medicaid Reimbursement Methods and Rates for Nursing Facilities, 2002.* Wichita, KS: Wichita State University.

Swan, J. H., S. DeWit, and C. Harrington. 2000. "Medicaid Nursing Facility Reimbursement Methods, 1992–1997." *Medical Care Research and Review* 57 (3): 361–78.

Thompson, J. D. 1967. *Organizations in Action.* New York: McGraw-Hill.

Tilly, J., K. Black, B. Ormond, and J. Harvell. 2003. *State Experiences with Minimum Nursing Staff Ratios for Nursing Facilities: Findings from Case Studies of Eight States.* Washington, DC: U.S. Assistant Secretary for Planning and Evaluation.

U.S. Bureau of the Census (USBOC). 2002. *Current Population Reports, P-25 Series.* Washington, DC: Population Estimates Branch, Bureau of the Census.

U.S. Bureau of Labor Statistics (USBOLS). 2003a. *Employment Status of the Civilian Noninstitutional Population by Sex Age, Race, and Hispanic Origin, 2000–2002 Annual Averages. Tables Created by BLS.* Washington, DC: U.S. Department of Labor [accessed July 2003]. Available at www.bls.gov/lau/table12full02.pdf

———. 2003b. *2002 Occupational Employment and Wage Estimates.* Washington, DC: U.S. Department of Labor [accessed July 2003]. Available at www.stats.bls.gov/oes/2001/oessrcma.htm

U.S. Centers for Medicare and Medicaid (USCMS). 2001. *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Facilities. Phase II Final,* Volume I, II, and III, Report to Congress. Washington, DC: Prepared by Abt Associates Inc., USCMS.

U.S. Centers for Medicare and Medicaid Services (USCMS), and Scully, T. 2003. *Health Care Industry MarketUpdate. Nursing Facilities.* Washington, DC: CMS.

U.S. Department of Commerce, Bureau of Economic Analysis (USDOC). 2002. *SA1-3. Per Capita Personal Income. Annual State Personal Income. Regional Accounts Data.* Washington, DC: Bureau of Economic Analysis [accessed July 2002]. Available at www.bea.doc.gov/bea/regional/data.htm

U.S. Department of Health and Human Services (USDHHS), Bureau of the Health Professions. 2003. *Area Resource File.* Washington, DC: USDHHS.

U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (USCMS). 2003. Medicare SNF Average Daily Payment Rates by State [accessed September 17, 2005]. Available at www.cms.hhs.gov/researchers/pubs/datacompendium/2003/03pg8283.pdf

U.S. General Accounting Office (USGAO). 2000. *Nursing Homes: Aggregate Medicare Payments Are Adequate Despite Bankruptcies. Testimony before the Special Committee*

on Aging, U.S. Senate. GAO/T-HEHS-00-192. Washington, DC: U.S. General Accounting Office.

———. 2002a. *Nursing Homes: Quality of Care More Related to Staffing than Spending: Report to Congressional Requestors. GAO/HEHS-02-431R.* Washington, DC: U.S. General Accounting Office.

———. 2002b. *Skilled Nursing Facilities: Medicare Payments Exceed Costs for Most but Not All Facilities*, Report to Congressional Requestors. GAO/HEHS-03-183 Washington, DC: U.S. General Accounting Office.

Wooldridge, L. M. 2003. *Introductory Econometrics*, pp. 300–2. Mason, OH: Thomson South-Western.

Zhang, Z. X., and D. C. Grabowski. 2004. "Nursing Home Staffing and Quality under the Nursing Home Reform Act." *Gerontologist* 44 (1): 13–23.

Zinn, J. S. 1993a. "Inter-SMSA Variation on Nursing Home Staffing and Management Practices." *Journal of Applied Gerontology* 12 (2): 206–24.

———. 1993b. "The Influence of Nurse Wage Differentials on Nursing Home Staffing and Resident Care Decisions." *Gerontologist* 33 (6): 721–9.

———. 1994. "Market Competition and the Quality of Nursing Home Care." *Journal of Health Politics, Policy and Law* 19 (3): 555–81.

Zinn, J.S, V. Mor, N. Castle, O. Intrator, and D. Brannon. 1999. "Organizational and Environmental Factors Associated with Nursing Home Participation in Managed Care." *Health Services Research* 33 (6): 1753–67.

Zinn, J.S, R. J. Weech, and D. Brannon. 1998. "Resource Dependence and Institutional Elements in Nursing Home TQM Adoption." *Health Services Research* 33 (2): 261–86.

AOTA

The American Occupational Therapy Association, Inc.

Occupational Therapy: Skills for the Job of Living

STATEMENT OF THE AMERICAN OCCUPATIONAL THERAPY ASSOCIATION SUBMITTED TO THE UNITED STATES SENATE SPECIAL COMMITTEE ON AGING, FOR THE HEARING ON "THE NURSING HOME REFORM ACT TURNS TWENTY: WHAT HAS BEEN ACCOMPLISHED, AND WHAT CHALLENGES REMAIN?" MAY 2, 2007

The American Occupational Therapy Association (AOTA) submits this statement for the record of the May 1, 2007 hearing. We appreciate the opportunity to provide comment.

AOTA represents more than 36,000 occupational therapists, occupational therapy assistants, and students of occupational therapy. Occupational therapy is skilled treatment that helps individuals achieve independence in all facets of their lives. Occupational therapy assists people in developing the "skills for the job of living" necessary for independent and satisfying lives. Occupational therapy is a health and rehabilitation service that helps individuals whose lives have been affected or could be affected by injury, disease, disability or other health risk. Clients who benefit from occupational therapy include infants and children, working age adults, and older persons all of whom are dealing with conditions affecting their ability to engage in everyday activities or "occupations." Occupational therapy practitioners are skilled professionals whose education includes the study of human growth and development with specific emphasis on the social, emotional, and physiological effects of illness and injury.

In 1986, the Institute of Medicine (IOM) conducted and reported on a study to determine how to better regulate the quality of care in the nation's Medicaid and Medicare certified nursing homes. The results of the IOM report laid the groundwork for the Federal Nursing Home Reform Act included in the Omnibus Budget Reconciliation Act (OBRA) of 1987. This legislation created national minimum standards of care and rights for people living in certified nursing facilities. The basic objective of the Nursing Home Reform Act is to ensure that residents of nursing homes receive quality care that will result in their achieving or maintaining their "highest practicable" physical, mental, and psychosocial well-being.

As the Committee looks at the accomplishments and challenges remaining since this legislation was implemented in 1987, AOTA would like to highlight how occupational therapy goes to the heart of the goals of the Nursing Home Reform Act. Occupational therapy starts where the person is, looks at their desires and potential, and facilitates diminishment of frailties and support of abilities. As individuals are treated in nursing homes, their needs range widely. Occupational therapy is there to assist and enable them to overcome or heal from disability and illness. It is a critical component to achieving quality of life which is the goal of quality in nursing homes. Our nation's population of older adults continues to grow and nursing homes will remain an important site of care for people who require constant nursing care and have significant deficiencies with activities of daily living. Quality must continue to be a primary goal.

The American Occupational Therapy Association, Inc. | 4720 Montgomery Lane Bethesda, MD 20814-3425 | 301-652-2682 301-652-7711 Fax | 800-377-8555 www.aota.org

Occupational Therapy's Role

Activities of Daily Living (ADLs) are basic self-care activities that need to be completed on a daily basis (for example self-feeding, grooming, bathing, dressing, and toileting). Instrumental activities such as reading and managing money are also critical. Occupational therapy practitioners work with nursing home patients and residents to gain the skills that are needed to accomplish their ADLs and pursue IADLs as appropriate. Occupational therapists and assistants are experts at identifying the causes of difficulties limiting participation. Changes implemented in OBRA brought new expectations that each nursing home resident's ability to walk, bathe, and perform other activities will be maintained or improved absent medical reasons. Occupational therapy practitioners continue to be an integral part of a nursing homes success in meeting resident's ADL and IADL goals and promoting "highest practicable" well-being.

The role of occupational therapy practitioners in nursing homes is to maintain and improve a resident's quality of life as well as to provide the best quality of care possible. The Centers for Medicare and Medicaid Services maintains an online survey, certification, and reporting database that includes nursing home characteristics and health deficiencies issued during the three most recent state inspections and recent complaint investigations, as directed by federal law. A majority of the measures included in the Minimum Data Set used to measure quality for the public are positively impacted by the use of occupational therapy services. Occupational therapy practitioners treat and educate residents and nursing home staff in a number of areas affecting quality as measured in nursing homes, including:

Falls Prevention

Falls are the leading cause of injury and accidental death in adults over the age of 65 years. New or unfamiliar surroundings, improper footwear, cumbersome furniture arrangements, and distractions all can cause a person to accidentally stumble and fall, causing a serious injury, even death. Falls are a leading cause of mortality among adults age 65 and older; one of every three older Americans – about 12 million seniors – fall each year. In 2004, in the United States, more than 14,000 older adults died from falls, approximately 1.8 million were treated in hospital emergency departments for unintentional fall-related injuries, and more than 400,000 of those were subsequently hospitalized. A recent analysis by the Centers for Disease Preventing and Control (CDC) determined that in 2000, among adults aged 65 and older, direct medical costs totaled $179 million for fatal fall-related injuries and $19.3 billion for nonfatal fall-related injuries. We agree with CDC that prevention of falls is a major public health goal, particular in nursing homes where residents are at a higher risk.

Occupational therapy practitioners evaluate and treat many older adults who are at risk for falls. In nursing homes, ensuring the safety of residents as they move about the facility is a high priority, particularly for those with balance problems or those who suffer from

delirium. Both prevention and rehabilitation programs are available as part of occupational therapy services in nursing homes. Occupational therapy promotes prevention by addressing the physical and sensory impairments of aging, eliminates environmental barriers by promoting "universal design" and recommends safety practices for common nursing home activities such as transferring and toileting. But occupational therapy can also deal with the fear of falling, which contributes to isolation, possibly depression, and seriously limits many older adults' participation even in nursing homes.

Eating, Feeding and Swallowing

Occupational therapy practitioners provide skilled care to residents in nursing homes who experience problems with eating, feeding and swallowing, all essential activities of daily living. These problems can be wide ranging and may include physical difficulty bringing food to the mouth or processing it in the mouth, dysphasia, psychosocially-based eating disorders, and eating or feeding dysfunction related to cognitive impairment. Occupational therapists provide screening and in-depth clinical assessments and work together with residents and staff to determine goals and optimal outcomes. Occupational therapists can also evaluate and provide special equipment for independence in eating, as well as instruct staff on how to improve residents self-feeding.

Positioning

Occupational therapy practitioners work with residents in maintaining and improving their positioning in bed and seats, including wheelchairs, in an effort to help residents avoid pressure sores and physical restraints. Pressure sores are skin wounds resulting from unrelieved pressure which prevents blood from reaching vulnerable parts of the body, mainly bony spots in weight-bearing areas. If the area of pressure is not relieved, the skin tissue can become infected and die. When dead tissue breaks down, the open wound that is created can be quite deep, sometimes going through all layers of skin to the underlying bone. Such dead tissue often becomes infected, and surgery is required to discharge it.

Occupational therapists educate residents on issues such as encouraging frequent changing of positions, switching from a wheelchair to a bed or chair throughout the day and timing of pressure releases. Occupational therapists also are trained to provide wheelchair assessments to determine what type and size wheelchair is appropriate for the resident's needs. These important services help to reduce pressure sores in nursing home residents and promote optimum safety and participation.

A recent IOM report, The Future of Disability in America (2007), details the lack of progress made in the last two decades to prepare for the aging of the baby boom generation and to remove the obstacles that limit what too many people with physical and cognitive impairments can achieve, including in a nursing home. The maturing of the baby boom generation is a challenge for Congress to consider when looking at the shortfalls of the Nursing Home Reform Act. Faced with more elders with different needs and demands,

nursing homes will have to change. It has been proven that elderly individuals benefit from occupational therapy services ***[Journal of the American Medical Association (JAMA) "Occupational therapy for independent-living older adults: A randomized controlled trail." JAMA, Vol. 278, No. 16, p. 1321-1326. 1997]***. AOTA hopes that Congress will continue to incorporate occupational therapy in discussions of how we can better serve our nation's nursing home residents and all aging Americans.

AOTA commends the Special Committee on Aging on taking the time to discuss the accomplishments and remaining challenges of the Nursing Home Reform Act. AOTA looks forward to continue working with Congress to better our nation's healthcare system.

Contact: Daniel R. Jones

CENTER FOR MEDICARE ADVOCACY, INC.
1101 VERMONT AVENUE, N.W., SUITE 1001
WASHINGTON, D.C. 20005
(202) 216-0028 FAX (202) 216-0119
www.medicareadvocacy.org

ATTORNEYS
Judith A. Stein*
Brad S. Plebani*
Pamela A. Meliso*
Gill Deford
Alfred J. Chiplin, Jr.
Toby Edelman
Vicki Gottlich
Patricia Nemore
Lara K. Stauning*
Mary T. Berthelot*
Mary A. Ashkar*
Ted J. Bliman*
Abigail C. Goff*

OF COUNSEL
Sally Hart*
Wey-Wey Elaine Kwok*

*Admitted in other jurisdictions

ADMINISTRATOR
Carolyn S. Boyle

DATA PROJECT DIRECTOR
Larry S. Glatz

SENATE SPECIAL COMMITTEE ON AGING

The Nursing Home Reform Act Turns Twenty: What Has Been Accomplished, and What Challenges Remain?

May 2, 2007

STATEMENT OF THE CENTER FOR MEDICARE ADVOCACY, INC.

The Nursing Home Reform Law,[1] enacted by Congress in 1987, is a remarkable achievement. It set a high standard of care, entitling each resident to receive all the care and services he or she needs in order to achieve and maintain the highest possible level of functioning, with full enjoyment of rights and quality of life. It set in place a comprehensive framework for regulating the nursing home industry through a publicly-accountable survey process. And it required state and federal governments to take swift and meaningful action against facilities that fail to provide residents with appropriate high quality care or violate these rights. The law was ground-breaking and inspirational when it was enacted and it remains so today. The million and a half people who live in nursing homes deserve no less than our nation's commitment to full implementation of the Nursing Home Reform Law.

Despite the excellence of the Nursing Home Reform Law and its success in improving quality of care and quality of life for residents in some respects, three changes are needed to achieve the full promise of the law.

1. Meaningful staffing standards must be enacted.
2. The survey process must be adequately funded to assure facilities' compliance with standards of care and to respond in a timely and meaningful way to complaints.

---

[1] 42 U.S.C. §§1395i-3(a)-(h), 1396r(a)-(h), Medicare and Medicaid, respectively.

3. The enforcement system needs to be revised to achieve the statutory mandate of swift and certain enforcement for all levels of noncompliance with standards of care.

Staffing

The Nursing Home Reform Law requires that facilities have "sufficient" staff to meet residents' needs.[2] This standard has not worked to assure that facilities have sufficient numbers of well-qualified and well-trained staff.

The nurse staffing study submitted to Congress by the Centers for Medicare & Medicaid Services in 2001 documented that more than 91% of facilities fail to have sufficient staff to prevent avoidable harm and that 97% of facilities do not have sufficient staff to meet the comprehensive requirements of the Reform Law.[3]

Raising reimbursement rates in the hope that facilities will increase their staffing levels as a result does not improve staffing. Congress increased Medicare reimbursement rates in 2000, specifically for nurse staffing.[4] The Government Accountability Office found that staffing levels remained stagnant and that staffing increased only when states mandated specific staffing ratios or made other policy changes directed specifically at increasing nurse staffing.[5] It is time to implement the staffing ratios that CMS identified nearly a decade ago.

The cost of adequate staffing is not prohibitive. The poor care that results from inadequate staffing takes a heavy financial toll. Poor care costs money that could be better spent on providing residents with good care from the outset and preventing avoidable bad outcomes for residents.[6]

---

[2] 42 U.S.C. §§1395i-3(b)(4)(C)(i), 1396r(b)(4)(C)(i)(1), Medicare and Medicaid, respectively.

[3] CMS, *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Phase II Final Report*, pages 1-6, 1-7 (Dec. 2001), http://www.cms.hhs.gov/CertificationandComplianc/12_NHs.asp (scroll down to Phase II report).

[4] Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Pub.L. 106-554, App. F, §312(a), 114 Stat. 2763, 2763A-498.

[5] GAO, *Available Data Show Average Nursing Staff Time Changes Little after Medicare Payment Increase*, GAO-03-176, page 3 (Nov. 2002), http://www.gao.gov/new.items/d03176.pdf. Nurse staffing time increased by 1.9 minutes per day; Registered nurse time decreased and licensed practical nurse and aide time increased.

[6] Charles D. Phillips documented that physically restraining residents is more expensive than not restraining them. Charles D. Phillips, et al, "Reducing the Use of Physical Restraints in Nursing Homes: Will It Increase Costs?" *American Journal of Public Health*, Vol. 83, No. 83 (March 1993). Avoidable pressure sores, avoidable incontinence, physical restraints, and other indicators of poor care cost billions of dollars each year. *Nursing Home Residents Rights: Has the Administration Set a Landmine for the Landmark OBRA 1987 Nursing Home Reform Law?* Hearing before the Subcommittee on Aging of the Senate Labor and Human Resources Committee, 102nd Congress, First Session (June 13, 1991) (A Majority Staff Briefing Memorandum, at 160, 175-177).

Survey

The budget for survey and certification activities needs to be increased at the state and federal levels to allow for sufficient numbers of well-trained, multi-disciplinary staff to conduct annual, revisit, and complaint surveys. Limited survey budgets lead to insufficient numbers of survey staff. Without a strong survey system to detect deficiencies, and the enforcement actions that may be imposed for documented deficiencies, many facilities will not provide care to residents in compliance with federal standards.[7]

Enforcement

The enforcement system has not assured compliance with federally-mandated standards of care. As the most recent GAO report[8] reiterates once again, the enforcement system is too lax and too tolerant of poor care for residents.

Deficiencies are undercited. The GAO[9] and State Auditors[10] repeatedly report that surveyors fail to identify and cite many deficiencies

Deficiencies are understated and undercoded. Deficiencies are described as less serious than they actually are. Many deficiencies are identified as causing no harm to residents when, in fact, they cause harm.[11]

Deficiencies are underenforced. The GAO has repeatedly shown that the Centers for Medicare & Medicaid Services and state agencies do not use the full range of sanctions

---

[7] Helena Louwe, Carla Perry, Andrew Kramer (Health Care Policy and Research, University of Colorado Health Sciences Center), *Improving Nursing Home Enforcement: Findings from Enforcement Case Studies* page 44 (March 22, 2007), http://www.medicareadvocacy.org/SNF_FinalEnforcementReport.03.07.pdf ("Although 'the case studies revealed that enforcement actions, if executed, have only a limited positive effect . . . it must be recognized that nursing home behavior changes seldom occurred without a formal citation." [hereafter University of Colorado, *Improving Nursing Home Enforcement*].

[8] GAO, *Efforts to Strengthen Federal Enforcement Have Not Deterred Some Homes from Repeatedly Harming Residents,* GAO-07-241 (March 2007), http://www.gao.gov/new.items/d07241.pdf [hereafter GAO 2007 Report]. The GAO has issued more than a dozen reports on nursing home survey and certification issues since 1998. These reports are listed at pages 92-93 of the 2007 report.

[9] *See, e.g.,* GAO, *Nursing Home Deaths: Arkansas Coroner Referrals Confirm Weaknesses in State and Federal Oversight of Quality of Care,* GAO-05-78 (Nov. 2004), http://www.gao.gov/new.items/d07241.pdf. *See also* University of Colorado, *Improving Nursing Home Enforcement*, supra note 7.

[10] *See, e.g.,* California State Auditor, *Department of Health Services: Its Licensing and Certification Division Is Struggling to Meet State and Federal Oversight Requirements for Skilled Nursing Facilities,* 2006-106 (April 2007), http://www.bsa.ca.gov/pdfs/reports/2006-106.pdf [hereafter California Auditor 2007]; Colorado State Auditor, *Nursing Facility Quality of Care: Department of Public Health and Environment, Department of Health Care Policy and Financing* (Performance Audit) (Feb. 2007), http://www.leg.state.co.us/OSA/coauditor1.nsf/All/D2FC96140165870D8725728400745D8C/$FILE/1767%20NurseHomePerf%20Feb%202007.pdf [hereafter Colorado Auditor 2007].

[11] GAO, *Nursing Home Quality: Prevalence of Serious Problems, While Declining, Reinforces Importance of Enhanced Oversight,* GAO-03-561 (2003), http://www.gao.gov/new.items/d03561.pdf; California Auditor, *supra* note 10; Colorado Auditor; *supra* note 10.

that are available. Remedies that are discretionary are imposed infrequently, per day and per instance civil money penalties are often imposed at the lower ends of the allowable ranges, and temporary management is almost unknown. The Secretary does not impose denial of payment for all Medicare and Medicaid beneficiaries, as authorized by law.[12]

Despite these serious shortcomings, recent research demonstrates that the survey and enforcement system is essential to securing compliance by nursing facilities. Without the system, facilities do not make necessary changes.[13]

The nursing home industry opposed the comprehensive enforcement provisions of the Nursing Home Reform Law as the law was being enacted in 1987 and it has continued its opposition ever since, often trying to weaken the law or undermine it, or both. For example, the American Health Care Association unsuccessfully challenged the per instance civil money penalty regulation that the Health Care Financing Administration promulgated in 1999.[14] Over the years, the industry has also developed a series of "quality initiatives" – *Quest for Quality*, *Quality First*, *Advancing Excellence in America's Nursing Homes* – that promise a commitment to high quality care, but that undermine the regulatory system by establishing alternative criteria for evaluating nursing facilities. In contrast to the criteria established by the regulatory system, these criteria reflect secret goals and targets for improvement that are voluntary, self-reported and unaudited, and lack public accountability.[15]

The Center for Medicare Advocacy is a private, non-profit organization, founded in 1986, that provides education, analytical research, advocacy, and legal assistance to help older people and people with disabilities obtain necessary health care. The Center focuses on the needs of Medicare beneficiaries, people with chronic conditions, and those in need of long-term care. The Center provides training on Medicare and health care rights throughout the country and serves as legal counsel in litigation of importance to Medicare beneficiaries nationwide.

Toby S. Edelman
Senior Policy Attorney
Center for Medicare Advocacy, Inc.
Washington, D.C.
May 9, 2007

---

[12] GAO, 2007, *supra* note 8.
[13] University of Colorado, *Improving Nursing Home Enforcement, supra* note 7.
[14] *American Health Care Association v. Shalala*, D.D.C., Civil No. 1:99CV01207 (GK) (case dismissed, March 6, 2000), unsuccessfully challenging final regulations published at 64 Fed. Reg. 13,354 (March 18, 1999), 42 C.F.R. §§488.430(a), 488.438(a)(2).
[15] Center for Medicare Advocacy, *The "New" Nursing Home Quality Campaign: Déjà vu All Over Again*, http://medicareadvocacy.org/AlertPDFs/2006/06_09.21.SNFQualityCampaign.pdf.

Sam Perlin
LONG TERM CARE ADVOCATE
CONSULTANT

4545 Cook Rd. #303
Houston, Tx 77072
Phone: 281-933-4533
Email Preferred: sperlin@aol.com

Statement for the Record of the May 2 Committee Hearing, "The Nursing Home Reform Act Turns Twenty: What Has Been Accomplished, and What Challenges Remain?"

When will justice come? When those who are not injured become as indignant as those who are.

I just want to say-look, this is really about us, and there is something we can do about it. There is such a thing as the common good. This is our deal and we run it. We just hired those people to drive the bus for us. It's our country. (Molly Ivins)

The best time to borrow money from a bank is when you don't need it. That way you can pay off the loan and have a good track record for when you really need a loan.
The best time to take an interest in the nursing home in your community is when you don't need it. That way you will have the time, the energy, the clout to make the nursing home an exceptional care facility.

The General Accountability Office has reported to Congress thousands of times on the negative conditions in the nation's nursing homes. Books have been written on how to choose a nursing home. New laws, rules, regulations abound-- a bureaucratic dream.
But not once has it been proposed that maybe the public really doesn't care enough to get actively involved. Not a lot involved, just a little.
Nursing homes get most of their income from Medicare/Medicaid. Mostly from Medicaid-- our tax money. The nursing homes contract with the state to perform certain functions on behalf of their clients. Nursing homes are surveyed yearly to see if they fulfill the contract. Sounds good. However, if the contract is not fulfilled, the survey is an exercise in futility with little enforcement.
One nursing home had a survey that showed 20 care deficiencies and 9

fire and safety deficiencies. The penalty was $250 per day for 40 days it took to submit the plan of correction. Not actual corrections. Just a plan. That plan usually is to "inservice the staff." In this nursing home, as in most others, the staff sees a 100% turnover every year.

The fine, then, amounts to $10,000. If the facility decides to pay instead of appealing the fine, they get a 35% discount, which leaves the penalty as $6500. When care is the deficiency, not enough staff is the cause. An aide earning $9 an hour makes about $18,000 a year. It is cheaper to pay the fine and save $11,000.

Anyone who is looking for a good nursing home, therefore, can't depend on government oversight. Advice books say to check for proper license. Check the Nursing Home Compare on the computer, check and check again. But what might work for consumer items doesn't work for nursing homes. The answer, though, is simple.

*Before you need a nursing home, choose one nearby.

*Contact the Ombudsman office to have them introduce you to the residents/family members as a helpful volunteer.

*Join or form a family council with other families of residents, and with community people as officers.

* Make sure an elected state official is connected to the board. It is most important to have an aide to the elected state official in whose district the facility resides on the board. If the State Representative or State Senator does not want to get involved, exercise your vote to get other officials.

*Get to know by email and phone the directors of the various agencies dealing with nursing homes: Ombudsman, Regulator, Representative and Senator aides. Just a "hello" with an introduction of what you are up to is sufficient to get their cooperation.

Knowing the regulations is important. In Texas they are available on the Internet, listed under Chapter 19. For clarification, anyone can contact the Department of Aged & Disabled. In Texas, we have an outstanding public servant, Bevo Morris, who has been knowledgeable, gracious, and responsive to our questions and concerns. But he won't know those questions or concerns unless we ask. Improving nursing homes is a challenge worth the effort. It also is a commitment that many in the community are able to make.

At a nursing home in my neighborhood, we have our board meeting at 6 p.m., to which we invite the nursing home's administration. At the board meeting we bring up concerns for the administration to address. The family council meets at 7 p.m. after the board meeting. We know that concerns by residents or families need to be aired when they happen, not a month later.

We arrange for residents and families to email their concerns to the Administrator and Director of Nurses with a copy to the Board Representative to follow up. While we try to work out problems in house, if necessary we go to the corporation that owns the nursing home or to the state regulatory agency.

There are plenty of retired people who can be involved in nursing home oversight. They have to be asked, and maybe even pressured a little. For over thirty years, advocates have been going the route of laws, rules, regulations, horror stories, exposes. Nothing has worked. We know our plan works because at one nursing home in Houston, we are doing it. Without making this effort, though, all the well-meaning advice books won't change the care and safety deficiencies that pervade nursing homes throughout the country.

My name is Cheryl Zuccola. I have a brother Tim Preneveau who is a brain injured resident in a Skilled Nursing Facility in Worcester, MA. My brothers injury began in December of 2005. I would like to submit a statement for the record on Nursing Home Reform Act, Turning Twenty.

1. I am not unfamiliar with the Medicaid, Mass health system. Unfortunately, my daughter suffers from Bipolar II, Chronic Asthma and other health issues. Now I am also dealing with my brothers complex condition of Anoxic Brain Damage. I have become friends with many disabled individuals and family members. I have also become enemies with Administration, and some staff members of the Skilled Nursing Facility. This is due to the fact that I have tried diligently to raise many concerns to the Quality of Care and practices at this home. It has and is exhaustive, emotional, heartbreaking, mind boggling, frightening, stressful, sleepless nights, frantic, panic, nail biting, anger, sorrow, eye opening experience!!!! Reality of what still needs immediate attention despite the millions of pleas from family members, advocates, and Legislatur! e.

This is one day in the life of my brothers and families journey;

Drive an hour each way to the facility. Still exhausted from the night before. Exhausted and angry again because we have the same conversations about the same health concerns, issues, quality of care. The lack of communication, medications, ADL's, CNA's, etc, etc, etc... The constant we understand and we will address these issues, again. The cover ups, the mismanagement, it is just overwhelming to say the least. I would think that the staff and management of these facilities would understand by now what should be done. It is as if you were talking to cement. No matter how many meetings you have to rectify the situations at hand, it is astounding that the very next minute you are in awe with what happens the minute you walk out the door of that meeting. Your facing the same challenges you just discussed two minutes ago. Why? Why?! Why?

How many years more will the residents and family members have to endure the hell they live in each minute? How many more battles, conversations, neglect, letters, reports, phone calls, emails, legislature, I understand, we are working on it's, the problems will be resolved, etc, does it take to be heard???????????????????????????? Are all of us not telling the truth? So many people with the same issues? We are angry, fed up with the system. My insides are rotting away with the thoughts of, are the staff caring for my brother today? Are they adhering to our Care Plan? Are the Cna's being trained properly? Are his braces on correctly today, did he get washed, did they check to see if he needs to be changed, does he need to be repositioned, is he comfortable, did they remember to shower him, take off his catheter, give him ROM, medications in order, are his arms, legs,! bottom, getting skin breakdowns due to him being in the same position for hours, did staff pass on the correct information to other shifts, is his face clean, is he perspiring, did they brush his teeth, put lotion on, ensure his feeding tube is not clogged, or did staff remember to shut off the feeding tube when changing him, is he in the 30 degree angle so he doesn't aspirate, is his air mattress inflated correctly, is his wheelchair aligned properly, do they have the equipment such as nebulizers, oxygen tanks, on hand???? On and on it goes. This is the real deal. This is what happens at these so called "homes". Staff getting slapped with a wet noodle for not doing their jobs correctly. Fear of retaliation for speaking up. It does exist, it is happening!!!! Still with all the laws in effect, how do we fix this relentless system???

Money, Insurance, and lack of punishment is what is severely lacking. It is the very core to why the culprits of mismangement and abuse still exist.

Ask my mother how she feels each time she visits??? You leave notes, talk to staff, everything is still the same. It doesn't really matter what you say. Her heartbreaking daily reminder of what she has to deal with every day, every waking minute.

Just one interview with the many families and residents of these facilities quoting what they have to say says it all. Quoting the truth of thier way of life.

I am not ungrateful to the people who are fighting and have fought to bring justice. I am honored, grateful and hopeful to those I have met along this journey. To the individuals who are living in the real world as my family is. Thank you.

Sincerely,

Cheryl Zuccola

Statement For The Record on The May 2 Senate Hearing
'The Nursing Home Reform Act turns Twenty: What Has Been Accomplished & What Challenges Remain?"

Submitted by Diane Reed, Program Director
Consumer Advocates For Better Care of
Montachusett Home Care Corporation
680 Mechanic Street
Leominster, Mass. 01453

A brief statement from a LTC Ombudsman of 18 years.

When I came into the Ombudsman Program as a LTC Ombudsman in January of 1989, I hadn't been in a nursing home before. OBRA '87(The Nursing Home Reform Act) was a mere two years old and had barely begun implementation. So I still had time to observe living conditions in a nursing home pre-OBRA. Some of the conditions back then that I observed were the use of 'posey belts' (those nasty vest-like restraints designed to keep a person from moving around in or out of their chair) and bed restraints.

I observed hallway after hallway of residents lined up and waiting—waiting—waiting in their wheelchairs, unoccupied, zoned out.

I saw staff members making decisions for the residents, without asking them or getting the resident's permission: what time to go to bed at night, what time to get up in the morning, being forced to take showers when their dementia caused them to be terrified of the procedure, being served food that they didn't like, without any alternative being offered.

Abusive situations were more common back then. Residents were isolated if they 'acted up' or had 'behaviors'. Abuse regulations were in place back then, but staff attitudes didn't reflect them and required education and training for staff was less consistant. Being a C N A was a dead-end, thankless, low paying, backbreaking job. No esteem, no recognition and no way to move up.

Mostly, many facilities had an atmosphere of being 'put away'. Society as a whole looked at a nursing home as the last stop before the grave. Morbid and sad, but true.

But slowly, bit by bit, improvement crept along. The OBRA began to be implemented over these 18 years and many, many things have changed dramatically in nursing homes. There are no more 'posey belts'. Residents are no longer restrained in their beds. Education, research, case study and regulations prevailed in releasing caregivers from the practice of restraining residents to 'keep them safe', translated, for staff convenience.

OBRA gave residents their "rights", the right to make choices about their care, what time they go to bed and get up, the foods they eat and what alternative meals they can choose, the right to help plan their care and be involved in it regularly, or even the right to refuse care.

In my small part of the country in Massachusetts, there were 37 nursing and rest homes in 1989. Today, there are 18 nursing and rest homes operating. Over the years, the facilities that provided sub-standard care were weeded out and closed. The facilities that remain operating, by and large, offer good care, thanks to OBRA. Is there still room for improvement? Absolutely, and likely always will be. But thinking back to how things were for residents pre-OBRA, I know of a certainty that the positive changes and gains for the residents in the quality of care and quality of life would never have happened by the good grace of the facilities themselves, especially the for profit facilities. It took the implementation of OBRA to bring about these changes. As time goes on and facilities become fully aware of culture change and the reality of the meaning of residents rights, it will still be the full implementation of OBRA that will keep the gains moving forward until the day when a nursing home is no longer a 'dirty word'. That has taken twenty years to accomplish and society must never let its guard down and let us slip back.

Statement for the Record of the May 2, 2007 Committee Hearing, "The Nursing Home Reform Act Turns Twenty: What Has Been Accomplished, and What Challenges Remain?"

Linda Sadden
State Long-Term Care Ombudsman
Louisiana

I have had the privilege of serving as Louisiana's Long-Term Care Ombudsman since 1991, about the same time that the final provisions of the Nursing Home Reform Amendments of OBRA '87 were to be implemented. Therefore, one of my early tasks was to understand the law and what it could mean for nursing home residents. Under the excellent tutelage of the National Ombudsman Center and the extraordinary advocates who staffed and volunteered with the National Citizens Coalition for Nursing Home Reform, I learned that the law established a new and remarkable standard of care for residents—a standard that, if met, could allow this nation to justly claim to provide for its vulnerable citizens in a humane and civilized way. I also learned that this standard was based, not in ideology but on the best practices of nursing homes around the country—on the work of caring people who had found a way to make it happen.

Since 1991, I am delighted to say that I have met many individuals who have devoted their energies and their abilities to achieving that standard—among them were ombudsmen, surveyors, professional care givers, family members and residents. I have seen the lives of individuals, both residents and care professionals, made better by efforts to embrace the opportunities envisioned by OBRA '87.

Unfortunately, as described by one journalist, the improvement seems to come at a glacial pace. While many facilities are embracing the promise of OBRA '87, many still seem to be stuck in an antiquated model of care and business despite the growing evidence that it is simply bad business to do so. The reasons for this seem to be myriad and deeply entrenched. The enforcement system does not seem to have the ability to discern, or the means necessary to close providers who are unable or unwilling to progress. State and federal regulators are under-resourced, as are many ombudsman programs. The means for training staff and providers in better methods and practices is under-developed. The reimbursement system is convoluted and fragmented.

Finally, but perhaps most importantly, the heart of what makes long-term care either a positive or horrendous experience, the quality of the interactions with direct care-givers and the sheer adequacy of the numbers of staff, is left unaddressed. I look forward to the day when they will not be necessary, but until that time, minimum staffing ratios must be established.

Thank you for this opportunity to comment.

Missouri Coalition for Quality Care
P.O. Box 7165, Jefferson City, Mo. 65102
Toll free 1-888-262-5644 Email: info@mcqc.com
www.mcqc.com

The Nursing Home Reform Act Turns Twenty:
What Has Been Accomplished, and What Challenges Remain?

Statement for the Record of the May 2, 2007 Hearing

The Nursing Home Reform Act of 1987 enacted laws, set standards, requirements, and called for accountability of the nursing home industry. And that was good. But where are the enforcement provisions and why are penalties not imposed on those who defy the law? Why are penalty fees negotiated? Obtaining information relative to penalty fees, both federal and state, is difficult and sometimes impossible.

The Anderson, Missouri fire in 2006 brought to light the lack of enforcement. The nursing home had insufficient staff, unqualified staff, no sprinkler system, and a long list of violations cited by DHSS. Now with a mandatory sprinkler system in Missouri, nursing home owners want the government to pay all or part of the installation cost. They ask for and receive federal and state monies, with no strings attached, to run their facilities. Does the money go to pay for additional staff, more qualified staff, incentives and salary increases for staff, or does it go into the pockets of the nursing home owners? Some of the owners receive salaries in the millions with stock options, yet their employees who are entrusted with the care of loved ones, receive minimal wages with no incentives to better their position.

Is the quality of care and quality of life of nursing home residents improving? Yes, we believe it is, but too slowly. The Missouri Department of Health and Senior Services has cut back on nursing home inspections, some eliminated. Many Hot Line calls are not being investigated and plans of correction can sometimes take as long as a year. Some facilities hire employees without consulting the Employee Disqualification List and it takes too long for the EDL to be updated. More facilities should have ombudsmen on board, but even with a federally mandated program, many homes are without.

If you make laws and they are not enforced, and there are ways around them that are exploited by nursing homes and their lawyers, how good are they? We need **enforcement** of the laws to fully protect our nursing home residents, the elderly and the disabled.

The Missouri Coalition for Quality Care (MCQC) is a non-profit advocacy organization concerned with the care and protection of the elderly and disabled in Missouri. Our primary goals are to cause an improvement in the quality of care and quality of life of nursing home residents and in-home clients, to assist Missourians make informed choices about long-term care, to monitor programs of the Missouri Department of Health and Senior Services (and other state agencies), and to monitor Missouri's laws and regulations relating to long-term care.

STATEMENT TO THE
SENATE SPECIAL COMMITTEE ON AGING
ON BEHALF OF
FRIENDS AND RELATIVES OF INSTITUTIONALIZED AGED (FRIA)
May 2007

Friends and Relatives of Institutionalized Aged, (FRIA), thanks Senator Kohl and the Senate Special Committee on Aging for your leadership and concern in calling attention to the health and living conditions of the elderly residing in federally funded nursing homes. We express our deep appreciation for the opportunity provided to FRIA to add our voice to your hearings entitled, "The Nursing Home Reform Act Turns Twenty: What Has Been Accomplished, and What Challenges Remain?"

Since 1976, FRIA has been NYS's unique consumer resource for free information and assistance on long term care issues, with a special focus on nursing home care. FRIA has played a pivotal role in reforming the industry since its inception. In addition, FRIA provides direct services to seniors and their informal caregivers, working to improve individual problems with long term care as well as positively impact the state system generally. FRIA's services include:

- Free telephone bilingual Helpline service that assists over 1,500 callers each year on a wide array of long term care concerns,
- Organizing, assistance and support for over 60 NYS Family Councils attendant to nursing homes, representing over 20,000 nursing home residents,
- Caregiver Advocacy Center that provides information and interventions on resident rights, family rights, and care complaints, and,
- Community education and outreach that educates seniors and their families on NYS's long term care system, reaching over 1,000 community members in 2006 alone, not counting media appearances.

Over 1.6 million people are living in nursing homes in the U. S. today; in New York State where FRIA is based there are 657 nursing homes with 120,347 certified beds. Generally, people in these homes suffer from chronic disease, physical disabilities and mental disabilities and/ or dementia and depend on professional assistance for day-to-day care and continued survival. They may or may not have close family or friends nearby to oversee their care. They depend on the compassion and professionalism of the nursing home staff to make their end of life days more dignified, supportive and as pain free as possible. It is our important grassroots, individual consumer work with the New York residents and their families that informs our policy insights and brings us to submit these comments today.

As you know, demographic projections predict a doubling by 2030 of people over 65 years of age, with expectations of increasing numbers of over 85 year olds and of those

with dementia. Addressing the issues presented by the NHRA is critical not only for those older Americans alive today, but also, given the staggering aging baby boomer demographics, so we can resolve the issues before the problems take on unmanageable proportions. The Nursing Home Reform Act has had notable successes in reducing restraints, in some cases reducing overmedication of residents, and in recognizing family and friend council organizations. Yet, it continues to miss its mark in ensuring the broader mission of the Act- to ensure that residents receive quality care that will result in their maintaining or achieving the highest practicable physical, mental, and psychosocial well being- largely because the following, important elements of our federal legal framework are absent:

1- Minimum staffing levels are not established for nursing homes,
2- State agency oversight, through surveys, complaint investigations, and sanctions, are weak and agencies are not made appropriately accountable to CMS,
3- Financial transparency of federally supported nursing home operations, with enforceable random auditing, is non existent,
4- Nursing home closures are not adequately addressed.

1- Minimum staffing levels are not established for nursing homes

Current federal and NYS laws only call for "sufficient" staffing in each home, a vague standard and one honored more in the breach than in the practice. The absence of an enforceable, federal standard has resulted in inconsistent and low staff levels in homes throughout the country. The GAO, HCFA/CMS, and FRIA's own Helpline callers, among others, consistently document that low levels of staffing directly result in poor resident outcomes: indignities, miseries, injuries, and deaths. CMS itself recommends minimum total (not including administrative) staffing levels that range from 2.75 to 3.9 hours per resident per day. Other experts, some of whom have testified before you in the hearings, recommend a higher level of hours per resident per day. It should be remembered that these are minimum standards, below which experts *expect* harm to residents will result. Evidence exists to indicate that no more than 10% of homes nationwide meet these minimum standards. In NYS, for example, a study was done by NYS Attorney General Elliot Spitzer, to determine the staffing levels in homes. This study found that 2% met this minimum standard. Moreover, in the last few years, the population living in nursing homes has become more frail and less competent. Thus, residents need even more staff time and attention than the population did when the experts developed these minimum standards.

Cases drawn from FRIA's Helpline can illustrate how low staffing levels translate into real life crises for our nations' elderly.

- A daughter is concerned because her 75 year-old father, who has both Alzheimer's disease and depression, is having difficulty swallowing. He needs to be fed slowly but the nursing home is attempting to place him on a feeding tube against his wishes. She requested that the facility take time to feed him, she knows her father enjoys eating his meals and will suffer greatly if he were denied that pleasure. Also, the daughter recently discovered her father developed a pressure

sore but the doctor did not notify her of this development and her father is being left in a wheelchair all day, which exacerbates this condition.

- A women's sister had a fracture and suffered a stroke, she was sent to a nursing home to recuperate and receive rehabilitative therapy. Her sister was not toileted or changed in a timely manner, frequently left to sit in her excrement, and developed a pressure sore and a painful rash.

- A daughter complains that her mother is depressed because she is rarely taken out of her room for activities, even though she is otherwise mentally competent.

- A spouse is afraid because his wife has lost 15% of her body weight since she arrived at the home a month ago, and seems to be missing meals and he is afraid she is wasting away.

Because most homes operate on a profit margin basis, there is no incentive for them to staff up to these higher needs without federal government intervention. For that reason, legislative requirements are the ***only*** way to ensure that appropriate staffing will occur. And, although some states have addressed the issue with lesser state standards, the nursing home program is largely a federally funded program, driven by CMS standards and reporting. It is therefore incumbent upon the federal government to take a strong lead in this area.

For that reason, FRIA supports federal legislation, like that introduced previously by Rep. Henry Waxman, that would require *minimum* nurse staffing ratios totaling 4.1-4.85 hours per resident per day. In March, FRIA personally delivered to Congress over 500 petitions from New Yorkers calling for this minimum staffing level in homes. Extracts from their heartfelt petitions reflect the urgency and pleas for this simple but meaningful reform:

> "Please remember all of us will be old at some time."
>
> "There are those people in facilities who have no one to help out if their care needs aren't met because of understaffing."
>
> "We are not just talking about the elderly. I speak for my 25 year old daughter."
>
> "It is an outrage that seniors who spent their lives taking care of us cannot achieve a standard of health care in nursing homes that secures adequate coverage for them!"

FRIA also supports the interim step urged in NCCNHR's testimony that Congress require CMS to collect accurate staffing data from the nursing homes and make this information available to the public. It is remarkable in this world of high tech data collection, that consumers and the government are forced to rely upon self-reported data about such a

crucial element of care and appropriate usage of federal money. Currently, staffing level data at homes are accepted by CMS with no independent verification of this information. Based on what families and residents tell us, we must seriously question whether the data provided by nursing homes to CMS is reliably accurate, and we fear that even the low levels currently reported are higher than what is provided to residents in actuality.

Establishing appropriate, minimum nursing staff levels in nursing homes is the single most important protective act we can take for the safety and well-being of our nation's elderly residents. Moreover, establishing staffing minimums will provide preventative protection for residents. It is a far better, more reliable model than continuing to solely rely on enforcement efforts of state agencies 'after the fact' of poor care, efforts we recognize are grossly inadequate. Care of the elderly requires personal attention. There is simply no short cut. Setting minimum staffing levels alone would give new meaning to the promise of the NHRA.

2- Lax government enforcement

It comes as no surprise to those who have loved ones living in nursing homes that the GAO's new report, "Nursing Home Quality and Safety Initiatives," found that homes are not sanctioned for non-compliance with federal standards, despite actual harm caused to seniors by their failures. Historically we have witnessed the GAO issue similarly glaring reports with no corresponding action from federal or state officials, evidencing a callous disregard for our frail seniors. In fact, there are numerous regulations governing quality of care that provide a basis for sustaining quality of care deficiencies as violations of law. Yet, according to the GAO, more than 300,000 elderly and disabled residents lived in chronically deficient nursing homes where they were "at risk of harm due to woefully deficient care." Other GAO reports have found that these figures actually understate the actual number and the seriousness of violations.

Part of the problem is that enforcement must be non negotiable and swiftly pursued when deficiencies are found- but it is not. We believe that the process by which survey findings are disputed by homes may provide an inappropriate opportunity for homes to 'reduce' both deficiency findings and fine imposition. We all recognize that, on occasion, a surveyor may make a mistake requiring appropriate supervisory discretion to modify the results. However, we have been led to believe that substantive changes are made to at least the state findings routinely, along with reduction of fines. This process undercuts the viability and credibility of surveyor work and misleads the public about the quality of care in nursing homes. In this regard, it should be remembered that the survey findings are key tools disclosed to consumers representing the government's professional assessment of the nursing home. By intentionally modifying the original survey results to minimize the findings, states are providing consumers with an erroneously 'better' picture of the home on which to rely. As such, consumers are deceived and potentially injured by this approach.

Surveyors in few states routinely speak to families and family councils to determine the consumer perspective about the quality of care and responsiveness of facilities. In New York State, it is a rare occurrence for surveyors to speak to residents or families, unless

these individuals are selected for conversation by the nursing home administration. More random conversations with consumers are necessary. And, such conversations must be private with the identity of the parties fully kept confidential. Off-site discussions are the best way to accomplish this result and most families we know would welcome the chance to provide helpful input.

FRIA believes that the government has the requisite knowledge and capacity to perform professional surveys appropriately. We would urge new training of surveyors to impress the need for thoroughness, inclusiveness of family, correct categorization of deficiencies, review of extant complaints against the nursing home, and ***proactive*** questions.

And, complaint investigations need to be beefed up, by detailing specific legislative process demands, and possibly monetary recourse for consumers who have been retaliated against because they raised complaints against a nursing home. During the past ten years, FRIA has answered over 14,000 telephone calls from residents and families raising nursing home complaints. Few substantiated complaints result in a statement of deficiencies. For example, in New York City only 22.9% were substantiated but only 4.7% received deficiencies in 2004. Similarly, in 2005 26.7% of complaints were substantiated but only 3.8% resulted in deficiencies. In some cases, the complainant was never interviewed by the state Department of Health. In others, the complainant was interviewed early on, but never given an opportunity to respond to the facility's arguments or explanations thereafter. Often, a complainant may have information demonstrating the falsity of a facility's account but is not given a chance to present it to the investigator. In most cases, DOH investigators seem to simply accept the facility's version of events and use it as the basis for not sustaining a complaint, not going beyond the four corners of the nursing home's documentation, even when conflicting documentation is presented by the consumer. And, there is no appeal mechanism for a consumer to challenge a finding, even if it involves allegations of serious, irrevocable harm.

In reconsidering the complaint process, it must be remembered that residents and families harbor tremendous fear of retaliation being directed against their vulnerable loved one or themselves, if they complain about a nursing home or staff member. It is easy for a retaliating nursing home to 'ignore' the resident of a complaining family member, or to restrict the family visits, on a wide variety of fabricated grounds. Given the enormous courage it takes to file such a complaint, it is truly disheartening and disempowering for a resident or family when its complaint is not sustained following an inadequate investigation.

3- Financial transparency

The lack of financial transparency results in significant opportunities for fraud, misinformation and confusion. On average, 67 percent of nursing home residents have their care paid for by the Medicaid program; 9 percent are covered by Medicare. The federal government is paying upwards of $50 billion/year for care. There must be accountability and transparency for how public dollars are being spent, especially given the serious findings of understaffed, inferior and deficient care. Nursing home chains are

proliferating, yet in NYS we have so far found it impossible to access ownership and investor interests in nursing homes. Nor do advocates and consumers – and possibly not even government – have any standard way of knowing how much money is actually being spent on direct care costs for their loved ones. Given the huge amount of state and federal dollars invested in nursing homes, financial transparency is critical to safeguarding the public's investment in these facilities, and assuming that the NHRA requirements are satisfied.

4- Nursing home closures

In recent years, governmental long term care policies across the states have focused on a shift from institutional to home and community based care. FRIA supports home and community based options for those who have the full resources to live safely and independently. Yet even if our communities offered a full range of accessible, affordable housing and coordinated health and social services (which they currently do not) our communities would still need nursing homes that are staffed beyond minimum standards and that support a dignified life to accommodate those with dementia, those without family/friends to oversee care, those who prefer socialized living settings, and more. Further, the shift from institutions is partly in response to overly simplistic and idealistic notions of independence that blind many to the complex caregiving needs of seniors and their families/friends. It is also dollar-driven by the questionable belief that home and community based care costs less than nursing home care. Consequently, instead of implementing policies to protect our nation's seniors in nursing homes, the nursing home model is being eroded by short-sighted state and federal policies.

For example, in New York, in 2004, Governor Pataki, like many other state officials, called for the closing of thousands of nursing home beds in the state. His statewide Commission to review the nursing home and hospital systems recommended that more than 3,000 nursing home beds statewide be cut. New York City alone will lose over 1,200 nursing home beds by 2008, despite its increasing senior population. Families are already hard-pressed to find nearby sub-acute and long term care beds upon hospital discharge or in response to health crises. Government needs to insist that strong protections be put in place to protect residents dislocated by voluntary and involuntary closures, that family/friends have the 'say' over where the resident will be transferred, and that there is oversight over to ensure that unbefriended residents are moved to appropriate facilities.

Conclusion

Although the issues presented by long term care are complicated and far reaching, enacting minimum safe staffing standards is not. Congress can better protect our seniors today by acting on this long overdue issue. It is that simple. If we fail to take the action that we all know is necessary, we are essentially saying that the frail elderly are disposable. We urge this committee to support this long-overdue and critical legislative effort.

We would be pleased to answer your questions or assist in any way we can as the Committees continue to review the urgent topics, staffing, enforcement, financial transparency, nursing home closures or any other topic that is raised as a result of the hearings.

Again, we thank Senator Kohl and the Senate Committee on Aging for your help and leadership, and for the opportunity to present some of our views.

Respectfully submitted,

Amy Paul
Executive Director

Statement for the Record
Senate Special Committee on Aging
May 2, 2007
"The Nursing Home Reform Act Turns Twenty: What Has Been Accomplished,
and What Challenges Remain?"

Rose B. McGarry, Ombudsman Program Director,
Elder Services of Merrimack Valley

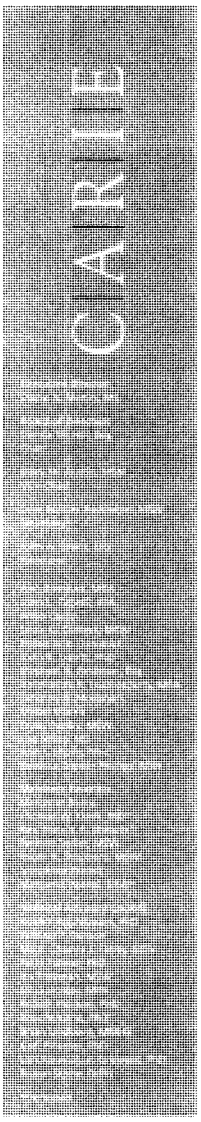
Since 1990 I have been involved in the nursing home industry as a social worker, family member and ombudsman. All roles have been advocacy roles. At times it is difficult to advocate when it appears a simple solution to the chronic complaints of lengthy call light response and inadequate activities, especially for those with dementia, could be resolved by increased staff. The 5 to 1 ratio which tried to be implemented with Senator Montigny's help a few years ago got blown out of the water.

I am a realist and understand that nursing homes are under huge financial distress; however, accepting the responsibility of caring for a resident must result in adequate care to help the resident maintain the highest quality of life as possible. Nursing homes appear to be taking on more than they can handle by accepting residents with substance abuse problems, mental health issues and behavioral issues that they cannot adequately handle. The supports are minimal.

Yes, I can attest to the fact that the residents are no longer "snowed" as in "pre-OBRA" days, but we still have to do better. We have to respect their wishes; keep them as independent as possible; and provide enough services to keep them and their fellow residents safe.

One quick story to illustrate the nursing home's occasional lack of acknowledgement of a problem and an easy solution to help improve the quality of life of a stroke resident:

An elder suffered a stroke in 2000; went into a nursing home with her own wheelchair (low because she is 5'2"). The care is good; however, she has recently outgrown her chair because of weight gain due to her inability to exercise (although she still self-propels in the wheelchair). The rehab team offered her a wider chair but standard height, so the resident naturally refused since she would lose her independence to propel herself throughout the facility. Head of rehab said since resident refused, that's the end of the facility's responsibility. They need only to provide a standard chair. Now the Ombudsman program is involved, and we will research all avenues to help this resident maintain her highest level of independence. But the solution appears to be a "no-brainer." We will ultimately prevail and our resident will be comfortable and safe, but should not this be the goal of each and every facility that accepts the awesome responsibility of caring for those who cannot care for themselves?



Senate Special Committee on Aging

"The Nursing Home Reform Act Turns Twenty: What Has Been Accomplished, and What Challenges Remain?"

May 16, 2007

Statement of the Center for Advocacy for the Rights and Interests of the Elderly (CARIE)

The Center for Advocacy for the Rights and Interests of the Elderly (CARIE) and its Philadelphia Long Term Care Ombudsman Program is pleased to be given this opportunity to acknowledge the 20th Anniversary of The Nursing Home Reform Law, OBRA '87. OBRA '87 has been instrumental in encouraging all stakeholders to work together to change the culture of the nursing home to make it a truly better place to live for our elderly. As a local ombudsman program serving a large urban area, we visit 3,000 residents living in 20 nursing facilities. CARIE regularly educates residents, family members and staff persons about resident rights. Our statement reflects our first hand experience of the impact of OBRA's accomplishments as well as the challenges that remain.

CARIE's ombudsman program was part of the nationwide effort sponsored by NCCNHR to define quality of care from the resident's perspective that informed the Nursing Home Reform Law. We utilize key principles set forth in OBRA '87 every day to ensure residents are educated about their rights, are given the opportunity to make informed decisions about their eare, and are empowered to exercise their rights to ensure their quality of life.

OBRA '87 created rights and opportunities that enable residents to take greater control of their lives through participating in the care planning process and in the survey process itself. The law also provides ombudsmen with the tools and support needed to educate residents and families about resident rights and about the performance of the nursing facilities in which they reside. We remember the days when the survey process consisted primarily of reviewing records, and when consumers and even the ombudsman had extremely limited access to long term care survey reports. In our area, consumers reviewed these records so infrequently that even the custodians of the information (the local Social Security offices) did not know where the reports were maintained! Since information is more readily available now, the ombudsman, residents and their families can be alerted to problems at prospective facilities as well as monitor the progress being made to remedy identified problems.

Thirty Years 30 in Service to the Elderly

Center for Advocacy for the Rights and Interests of the Elderly
100 North 17th Street, Suite 600 Philadelphia, PA 19103
T: 215.545.5728 F: 215.545.5372 W: www.carie.org

United Way of Southeastern Pennsylvania

Although several facilities in Southeastern Pennsylvania were pioneers in restraint reduction even before OBRA '87, many nursing home residents in the state were physically and chemically restrained prior to the new law. OBRA provided an additional impetus for facilities in our state to recognize best practice and to drastically reduce the use of restraints to the extent where today, the ombudsman is sometimes called upon by family members who mistakenly believe that restraints would provide greater safety and promote better quality of life for their loved ones, but the nursing facility will not employ them.

While it is true that OBRA '87 has paved the way to "promote and protect the rights of each resident" and places a strong emphasis on individual dignity and self determination there is still much more work to be done.

Dignity and Respect

Residents of long term care facilities regularly reach out to the ombudsman program for assistance in realizing their right to be treated with dignity and respect. Their complaints often focus on the tone or attitude of the caregiver rather than the content or the words that are used. This subtle difference is not easily substantiated by surveyors unless the incident is witnessed by a bystander who is considered to be reliable. Residents' voices must continue to be heard as well as believed, and we must all work harder to eliminate failures to promote and protect dignity and respect in long term care. It is important that facility staff at all levels receive training to ensure they have the needed communication skills and understand the impact their communication style has on residents. It is also important for survey staff to receive training so that they can more readily identify and substantiate this common but overlooked problem.

Residents' voices must be heard

Residents' experiences as reported to surveyors must also be heard. As recently as April 2007, an ombudsman attended a closed resident meeting conducted by the PA Department of Health during its annual survey. Residents told the inspectors about their continued problems with call bells, stating that their call bells are not answered in a timely manner or that staff come in and turn off their bells without providing the needed care. They must then wait to receive help. Even though residents voiced these concerns to the inspectors and the ombudsman verified their complaints based upon a number of open cases, the inspectors did not substantiate these complaints or cite them at the level of a deficiency. To no one's surprise, they were also unable to verify these complaints through observation while conducting their inspection. We echo Alice Hedt's (Executive Director, NCCNHR) statement that residents should have the right to challenge survey findings that do not appropriately address deficiencies experienced by residents.

Insufficient Staffing

Over the past three years, 32% of the complaints received by our local ombudsman program were care related. The highest number of complaints received by the

ombudsman (in order from most frequent to least) are, personal hygiene, complaints of not being turned, improper handling, failure to respond to requests for assistance and medication administration and organization. Half of these complaints were verified.

Most of the care complaints that the ombudsman receives and observes at facilities can be remedied by better staffing levels for all shifts. Residents regularly complain to the ombudsman about staffing levels at nursing homes, stating their needs are not being met because of insufficient staffing. Residents have even told the ombudsman that sometimes they don't ask for help when they need it because they feel bad for the caregivers.

The residents' needs range from those related to basic quality of care such as being assisted to the bathroom or being changed promptly when that assistance is not provided, to quality of life issues like being unable to enjoy the fresh air and sunshine on a beautiful day because there is no staff person available to assist them to leave the building or to provide supervision.

We have also received anonymous calls from staff people who want to convey to the licensing agency that their facilities' payroll records should be examined to corroborate the records of staffing levels. These situations must change. In order to truly promote an atmosphere that emphasizes individual dignity and self determination, facilities must have the staffing necessary to be able to provide basic care and enable the choices that residents make.

CARIE also recognizes other connections between the experiences of direct care workers and residents, and supports the need to address workforce issues as a crucial part of realizing quality long term care. CARIE leads a statewide coalition, Better Jobs, Better Care PA, to advocate for changes in Pennsylvania that will positively impact the working conditions, benefits, and career options for direct care workers with the goal of improving quality of care for residents.

It is extremely frustrating to continue to witness the problems that frail older adults endure from poor staffing and, that after 20 years, since the passage of OBRA, to realize more hasn't been done to address the staffing problems in nursing facilities. There is overwhelming evidence from research, from residents and their families, and even the staff themselves about the detrimental impact of inadequate staffing levels. We hope that Congress will finally address this major problem and implement and enforce policies necessary to ensure facilities are adequately staffed to meet residents' needs.

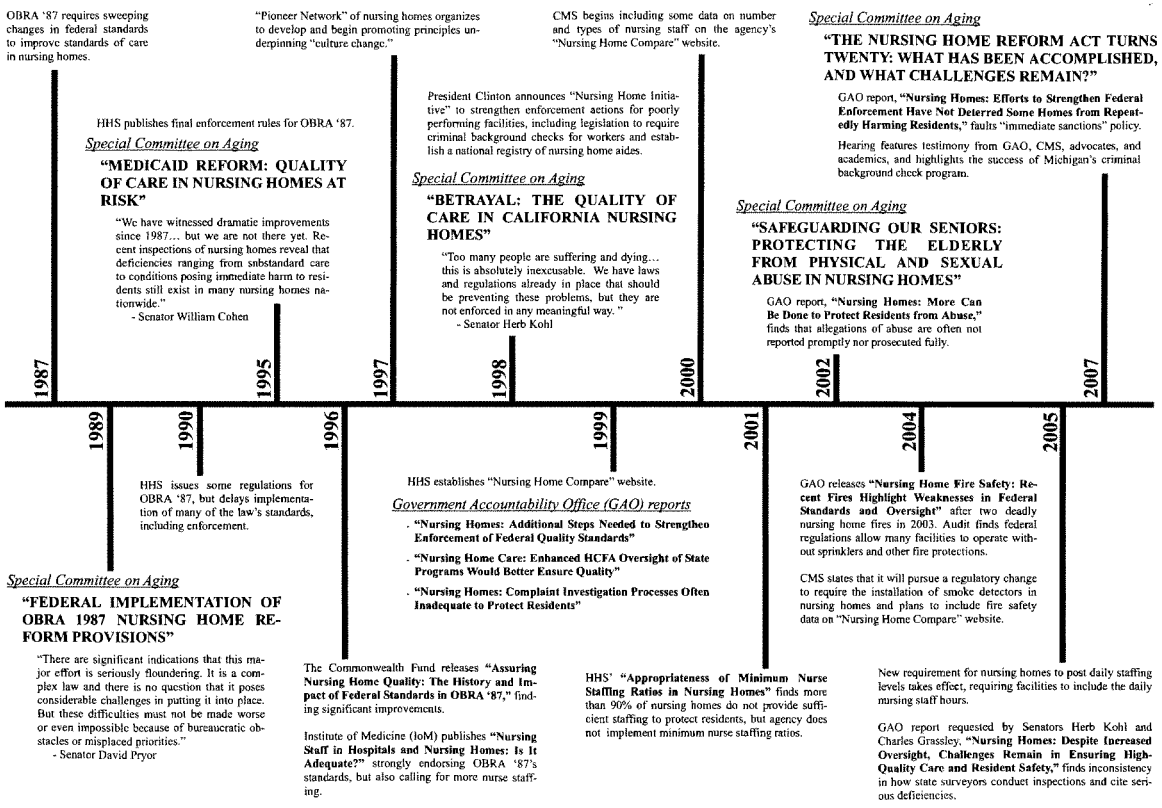
Founded in 1977, CARIE is a nonprofit organization dedicated to improving the quality of life for frail older adults. CARIE's focus of concern spans the long term care continuum from those who are homebound to those who are institutionalized. Older adults who experience physical frailty or psychological impairment frequently have difficulty advocating for their needs and are often a silent group. CARIE works to protect their rights and promote awareness of their special needs and concerns.

In conclusion, CARIE urges Congress to build upon the accomplishments of OBRA, consider our recommendations as well as support the recommendations made by NCCNHR and Charlene Harrington. Thank you for the opportunity to provide comments. I can be contacted at 215-545-5728 or menio@carie.org for any questions or clarification.

Respectfully Submitted,

Diane A. Menio
Executive Director

NURSING HOME REFORM ACT (OBRA '87): 20 YEARS OF HISTORY



OBRA 1987 TIMELINE – MAJOR EVENTS

1935
Passage of Social Security Act (SSA): As enacted, law does not allow payments to be made to residents of state-administered "public institutions," stimulating growth of proprietary nursing homes.

1950
SSA amendments allow the federal government to pay providers directly for nursing home services. Amendments also allow payments to public institutions and require states to establish basic licensing standards for nursing homes.

1965
SSA amendments creating Medicare and Medicaid pay for skilled services in nursing facilities. Fewer than 15% of nursing homes meet required federal safety and quality standards.[1] States are given authority to set standards for Medicaid.

Early 1970s
A series of reports of fires and food poisoning deaths in nursing homes, as well as other safety and quality problems, increase pressure on the federal government to take a stronger role in oversight. Senate hearings are held to address the nursing home quality problems.

1971
The Nixon Administration announces eight-point plan to improve conditions in nursing homes, including regulatory initiatives to centralize federal enforcement efforts and increase federal funding for nursing home inspections.

The President directs the Department of Health, Education, and Welfare (HEW) to assist states in establishing investigative units to respond to complaints by nursing home residents, the first step in creating what would become the Long-Term Care Ombudsman Program.

1975
Colorado nursing home residents sue federal and state officials for failure to adequately protect them.[2]

Senate Special Committee on Aging issues a major nine-part report over a series of months, "Nursing Home Care in the United States: Failure in Public Policy." In this report, Sen. Frank Moss comments, "Public policy has failed to produce satisfactory institutional care – or alternatives – for chronically ill older Americans. Long-term care for older Americans stands today as the most troubled, and troublesome, component of our entire health care system."

---

[1] U.S. Senate. 1970. Medicare and Medicaid: Problems, Issues, and Alternatives. Report of the Staff to Committee on Finance. Committee Print, 91st Congress, 1st Session, February 9. Washington, D.C.: U.S. Government Printing Office.
[2] Estate of Smith v. O'Halloran.

Early 1980s
Reagan Administration announces effort to shift most federal oversight of nursing homes to the states, and proposes major changes in the survey process for determining compliance by nursing homes with federal standards. Intense public opposition develops and leads to two Congressional moratoria prohibiting the Administration's deregulatory activity. Subsequently, Congress and the Administration agree to a study of nursing homes by the Institute of Medicine (IoM).

1984
10th Circuit Court of Appeals rules in the 1975 Colorado case that HHS has a duty to ensure high quality care for nursing home residents.[3]

1986
IoM report, "Improving the Quality of Care in Nursing Homes," includes recommendations for strengthened federal quality and safety standards for nursing homes; a comprehensive survey and inspection process; and financial penalties and other sanctions for facilities found to have deficiencies (http://books.nap.edu/openbook.php?isbn=0309036461). The National Citizens' Coalition for Nursing Home Reform launches the Campaign for Quality Care, which builds a consensus among consumers, providers, health care professionals, and workers on provisions that should be included in a new reform law to implement the IoM's recommendations.

Senate Special Committee on Aging holds hearing on May 21, 1986, "Nursing Home Care: The Unfinished Agenda," and releases the findings of a 2-year staff investigation of the status of care in the Nation's federally certified nursing homes. Senator John Heinz states, "Frankly, the news, after all these years, is still grim... We have warehoused tens of thousands of our oldest, sickest citizens, and the Federal government is not doing anything about it."

1987
The GAO issues a report (GAO/HRD-87-113) "Medicare and Medicaid: Stronger Enforcement of Nursing Home Requirements Needed" demonstrating that over a third of the nursing homes in 1985 failed to meet one or more of the requirements considered to be most likely to affect residents' health and safety during a 4 year period (http://archive.gao.gov/d29t5/133937.pdf).

Reps. Henry Waxman, Claude Pepper and Sens. George Mitchell, John Glenn, and Aging Committee chair John Heinz sponsor and lead debate on the Nursing Home Reform Act that incorporates key recommendations from 1986 IoM report, "Improving the Quality of Care in Nursing Homes." The resulting law, OBRA '87, requires sweeping changes in federal standards to improve standards of care: annual inspections of facilities; financial penalties and other sanctions for poor care; standardized system for assessing residents' health; minimum staffing requirements; standards to promote individualized care; and residents' rights.

1989
Senate Special Committee on Aging holds oversight hearing on May 18, 1989, "Federal Implementation of OBRA 1987 Nursing Home Reform Provisions." Sen. David Pryor warns,

---

[3] *Estate of Smith v. O'Halloran*, 557 F.Supp. 289 (D.Colo. 1983), *rev'd sub. nom., Estate of Smith v. Heckler*, 747 F.2d 583 (10th Cir. 1984).

"there are significant indications that this major effort is seriously floundering. It is a complex law and there is no question that it poses considerable challenges in putting it into place. But these difficulties must not be made worse or even impossible because of bureaucratic obstacles or misplaced priorities."

1990
HHS issues some regulations for OBRA '87, but implementation of many of the law's standards, including enforcement, is delayed.

1991
The federal government requires all nursing homes to conduct assessments of individual residents using a standard Minimum Data Set form on a periodic basis. Nursing homes are required to use the assessments for developing an interdisciplinary, individualized plan of care for each resident. The data are required to be submitted quarterly to the Health Care Financing Administration (HCFA), where the data are used for establishing a Medicare casemix reimbursement system based on resident care needs. The data are also used for monitoring quality by the state survey agencies. Some states use the Minimum Data Set to set Medicaid reimbursement rates.

1995
HHS publishes final enforcement rules for OBRA '87. State surveyors are required to rate violations of quality and safety standards (called deficiencies) according to their scope and severity. Broadly, deficiencies are defined as problems found to have resulted in, or problems that have the potential to produce, a negative impact on the health, safety, welfare, or rights of residents. Sanctions for identified deficiencies are tied to the scope and severity of the violation.

Senate Special Committee on Aging holds hearing on October 26, 1995, "Medicaid Reform: Quality of Care in Nursing Homes at Risk." Sen. William Cohen declares, "we have witnessed dramatic improvements since 1987... but we are not there yet. Recent inspections of nursing homes reveal that deficiencies ranging from substandard care to conditions posing immediate harm to residents still exist in many nursing homes nationwide." Sen. Russell Feingold notes, "it was this very Committee that was in large part responsible for the nursing home regulations that were enacted as part of OBRA '87. And if federal standards are to be maintained in this area, it will again be because of this Committee."

1996
A private foundation, The Commonwealth Fund, releases a study, "Assuring Nursing Home Quality: The History and Impact of Federal Standards in OBRA '87." The study finds significant improvements in resident care have occurred in nursing homes nationwide. Among the improvements: A 50 percent reduction in the use of physical restraints; significant increase in the involvement of families in care decisions; and reduction of psychotropic drug use by as much as a third.[4]

---

[4] Assuring Nursing Home Quality: The History and Impact of Federal Standards in OBRA-87, Catherine Hawes, The Commonwealth Fund, December 1996

IoM publishes "Nursing Staff in Hospitals and Nursing Homes: Is It Adequate?" strongly endorsing OBRA '87's federal standards and calls for improved professional nurse staffing. The report states, "the preponderance of evidence, from a number of studies using different types of quality measures, shows a positive relationship between nursing staff levels and quality of nursing home care, which in turn indicates a strong need to increase the overall level of nursing staff in nursing homes" (http://www.nap.edu/catalog.php?record_id=5151).

1997

"Pioneer Network" of nursing homes organizes to develop and begin promoting principles underpinning "culture change."

The Balanced Budget Act of 1997 (http://thomas.loc.gov/cgi-bin/query/z?c105:H.R.2015.ENR:) approves the Medicare prospective payment system (PPS) for skilled nursing facility services provided to Medicare beneficiaries, which is intended to link payment to residents' needs and to control the growth in Medicare spending.

1998

U.S. Government Accountability Office (GAO) releases report (GAO/HEHS-98-202) requested by the Special Committee on Aging, "California Nursing Homes: Care Problems Persist Despite Federal and State Oversight," at a Committee hearing called by Sen. Charles Grassley on July 28, 1998, "Betrayal: The Quality of Care in California Nursing Homes." Sen. Herb Kohl states, "too many people are suffering and dying...this is absolutely inexcusable. We have laws and regulations already in place that should be preventing these problems, but they are not enforced in any meaningful way" (http://www.gao.gov/archive/1998/he98202.pdf).

President Clinton announces "Nursing Home Initiative" that aims to strengthen sanctions for poorly performing facilities, including legislation to mandate criminal background checks for workers and establish a national registry of nursing home aides. He also announces that HCFA will establish a consumer information system to report data on the quality of nursing homes (http://www.hhs.gov/news/press/1998pres/980721a.html).

HHS implements the Medicare PPS payment system. Under PPS, skilled nursing facilities are given a prospective reimbursement rate based on resident casemix, with regional cost differentials, but facilities do not have to account for nurse staffing and therapy services delivered to residents.

1999

The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (http://www.congress.gov/cgi-lis/bdquery/z?d106:H.R.3426:) increases the payment rate for Medicare skilled nursing facilities temporarily for 2001 and 2002.

GAO report (GAO/HEHS- 99-46), "Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards," concludes that while the federal government "has taken steps to improve oversight of nursing home care, it has not yet realized a main goal of its enforcement process – to help ensure that homes maintain compliance with federal health care standards" (http://www.gao.gov/archive/1999/he99046.pdf).

"Nursing Home Care: Enhanced HCFA Oversight of State Programs Would Better Ensure Quality" (GAO/HEHS-00-6), finds weaknesses in federal and state monitoring of nursing home quality and recommends a series of regulatory and administrative changes to improve oversight (http://www.gao.gov/new.items/he00006.pdf).

"Nursing Homes: Complaint Investigation Processes Often Inadequate to Protect Residents" (GAO/HEHS-99-80) finds procedures or practices that may limit the filing of complaints, understatement of the seriousness of complains, and failure to investigate serious complaints promptly. The report recommends stronger federal requirements for states to promptly investigate serious complaints (http://www.gao.gov/new.items/he99080.pdf).

HHS establishes its Medicare "Nursing Home Compare" website to provide information on over 16,000 nursing homes, including information on facility characteristics and deficiencies. The website receives approximately 100,000 visits per month.

2000

Charlene Harrington and colleagues argue in the *Journal of Gerontology* that "strong evidence supports the relationship between increases in nurse staffing ratios and avoidance of critical quality of care problems... In 2000, over 91% of nursing homes have nurse aide staffing levels below that identified as minimally necessary to provide all the needed care processes that could benefit their specific resident population."[5] Subsequently, the Centers for Medicare & Medicaid Services (CMS) begins including limited data on number and types of nursing staff on the agency's "Nursing Home Compare" website.

GAO report (GAO/HEHS-00-197) "Nursing Homes: Sustained Efforts Are Essential to Realize Potential of the Quality Initiatives" shows that while improvements have been made in the survey process and in reducing the predictability of the timing of surveys, the improvements are modest (http://www.gao.gov/archive/2000/he00197.pdf).

2001

A federal government report, "Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes," finds clear evidence of adverse outcomes in facilities with minimum required staffing levels that serve residents with complex needs. This report shows that improvements in staffing at 4.1 hours per resident per day for long stay residents reduce the probability of substantial harm or jeopardy to residents. The study finds that more than 90 percent of nursing homes do not meet the level of staffing needed to protect residents. It does not recommend minimum nurse staffing ratios but demonstrates that facilities that provide below 4 hours of nursing care a day cannot provide all needed services to avoid harm to residents.

IoM report, "Improving the Quality of Long-Term Care," finds "the quality of care in nursing homes may have improved in some areas during the past decade, to a large extent due to provider response to the 1987 Nursing Home Reform Act and the forces that gave rise to this legislation....[but] the evidence also suggests that serious quality problems appear to continue to

---

[5] Harrington, Charlene, Zimmerman, David, Karon, Sarita L., Robinson, James, Beutel, Patricia Nursing Home Staffing and Its Relationship to Deficiencies J Gerontol B Psychol Sci Soc Sci 2000 55: S278-287

affect residents of this country's nursing homes, with persistently poor providers of care remaining in operation" (http://www.nap.edu/books/0309064988/html/).

2002

Senate Special Committee on Aging holds hearing on March 4, 2002, "Safeguarding Our Seniors: Protecting the Elderly from Physical and Sexual Abuse in Nursing Homes." Sen. John Breaux declares, "as a nation must not tolerate abuse of our senior citizens in any form nor in any place. The Special Committee on Aging spent 14 years from way back in 1963 to 1977 investigating nursing home care... [yet] in the year 2002, [nearly] 40 years have passed without a determination that nursing homes are safe for seniors." At the hearing, a GAO report (GAO-02-312) "Nursing Homes: More Can Be Done to Protect Residents from Abuse," documents that: allegations of physical and sexual abuse of nursing home residents are often not reported promptly; few allegations of abuse are ultimately prosecuted; and safeguards to protect residents from potentially abusive individuals are insufficient at both the federal and state levels (http://www.gao.gov/new.items/d02312.pdf).

GAO report (GAO-03- 183) "Skilled Nursing Facilities: Medicare Payments Exceed Costs for Most But Not All Facilities" shows that in 2000, the median Medicare profit margin is almost 19 percent (http://www.gao.gov/new.items/d03183.pdf).

CMS develops quality indicators using the quarterly reports on residents from the Minimum Data sets, and announces that 10 indicators will be selected for launching on its Medicare "Nursing Home Compare" website in 2002. GAO issues a report (GAO-03-187), "Nursing Homes: Public Reporting of Quality Indicators Has Merit, but National Implementation Is Premature," saying that adding new public information on quality to the existing public data on nursing homes has merit, but it recommends that CMS delay reporting in order to address problems with the quality information and its reporting (http://www.gao.gov/new.items/d03187.pdf). Another GAO report (GAO-02-279), "Nursing Homes: Federal Efforts to Monitor Resident Assessment Data Should Complement State Activities," finds problems with the accuracy of the MDS data and the state oversight of nursing home MDS reporting. The report urges CMS to improve its assessment and monitoring of the adequacy of state MDS accuracy efforts, given the importance for nursing home payments and resident care (http://www.gao.gov/new.items/d02279.pdf).

Representative Henry Waxman and Senator Charles Grassley issue a special report "HHS 'Nursing Home Compare' Website Has Major Flaws," pointing out that data on deficiencies related to resident complaints and other serious quality violations, such as immediate jeopardy, are not reported on the website.

2003

GAO issues a new report (GAO-03-561) on nursing home quality entitled "Prevalence of Serious Problems, While Declining, Reinforces Importance of Enhanced Oversight" that identifies weaknesses in state survey, complaint and enforcement activities that continue to understate serious quality problems. Poor investigation and documentation of deficiencies, limited quality assurance systems, and inexperienced state surveyors are factors (http://www.gao.gov/new.items/d03561.pdf).

IoM issues a report "Keeping Patients Safe," which makes recommendations for improving quality of care in hospitals and nursing homes (http://www.nap.edu/books/0309090679/html/). The report recommends that DHHS update existing regulations established in 1990 to specify minimum standards for registered and licensed nurses, require the presence of at least one registered nurse at all times, and implement the staffing ratios in the DHHS report to Congress "Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes – Phase II Final Report."

2004

GAO releases "Nursing Home Fire Safety: Recent Fires Highlight Weaknesses in Federal Standards and Oversight" (GAO-04-660) after two deadly nursing home fires in 2003, showing that although a large number of nursing home fires occur each year, federal regulations allow existing facilities to operate under waivers, without sprinklers and other fire protections. The report concludes that state and federal oversight of nursing home fire safety is inadequate (http://www.gao.gov/new.items/d04660.pdf).

A paper, "Effects of Medicare Payment Changes on Nursing Home Staffing and Deficiencies" published in *Medical Care* by R.T. Konetzka and colleagues shows that professional nursing staff decreased and regulatory deficiencies increased after the adoption of the Medicare prospective payment system (http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1361020).

CMS states that it will pursue a regulatory change to require the installation of smoke detectors in nursing homes and plans to include fire safety data on "Nursing Home Compare" website.

2005

New requirement for nursing homes to post daily staffing levels takes effect, mandating that nursing facilities include the total hours worked each day by nursing staff directly responsible for resident care.

GAO report (GAO-06-117) requested by Senators Herb Kohl and Charles Grassley, "Nursing Homes: Despite Increased Oversight, Challenges Remain in Ensuring High-Quality Care and Resident Safety," finds inconsistency in how state surveyors conduct inspections and understatement by state surveyors of serious deficiencies (http://www.gao.gov/new.items/d06117.pdf).

2006

A report, "Nursing Facilities, Staffing, Residents and Facility Deficiencies, 1999 Through 2005" by C. Harrington and colleagues, 2006 shows that since the adoption of PPS, the average registered nurse staffing hours per resident day has declined by 25 percent. (http://www.pascenter.org/documents/OSCAR2005.pdf)

2007

Special Committee on Aging holds hearing in May on the 20th anniversary of OBRA 1987, "The Nursing Home Reform Act Turns Twenty: What Has Been Accomplished, and What Challenges

Remain?" The hearing features testimony from GAO, CMS, advocates, the nursing home industry and academics, and highlights the success of Michigan's program that requires long-term care facilities to screen workers for a possible history of substantiated abuse and/or a criminal background as a condition of hiring.

GAO issues report, "Nursing Homes: Efforts to Strengthen Federal Enforcement Have Not Deterred Some Homes from Repeatedly Harming Residents," (GAO-07-241) which faults CMS' "immediate sanctions" policy, finding continuing quality problems in poorly performing nursing homes studied previously (http://www.gao.gov/new.items/d07241.pdf).

BROKEN PROMISES II

An Assessment of the District of Columbia's Initiatives to Improve Quality of Care in Nursing Facilities 2003-2005

Prepared by

The District of Columbia Long-Term Care Ombudsman Program

April 2006

BROKEN PROMISES II

An Assessment of the District of Columbia's Initiatives To Improve Quality of Care in the District's Nursing Facilities, 2003-2005

I. INTRODUCTION:

Under the Older Americans Act of 1965 and the District of Columbia's Long-Term Care Ombudsman Program Act of 1988, the Ombudsman Program is mandated to investigate and resolve complaints on behalf of residents in nursing homes, encourage citizens' involvement in improving nursing home quality, and monitor the development and implementation of regulations, laws and policies affecting nursing homes residents. In keeping with this mandate, the District of Columbia Office of the Long-Term Care Ombudsman, in November 2003, issued a report entitled "Broken Promises: An Interim Assessment of the District of Columbia's Initiatives to Improve Quality of Care in Nursing Facilities, 2002 – 2003." This report was prompted by the Ombudsman Program's concerns that D.C. nursing homes had serious quality of care problems and that the District of Columbia's Department of Health was failing to implement the District's nursing home regulations in a timely fashion, to properly enforce federal nursing home regulations, and, generally, to protect and promote the health and welfare of those residing in the District's long-term care facilities.

These concerns of the Ombudsman Program, and of other District organizations that advocate on behalf of the elderly and disabled, were expressed for a number of years both to officials at the D.C. Department of Health and to Congresswoman Eleanor Holmes Norton, who, in 2001, requested the Special Investigations Division of the Committee on Government Reform of the U.S. House of Representatives to prepare a report on nursing home care in the District of Columbia. A draft of that Congressional Report, Nursing Home Conditions in the District of Columbia: Many Homes Fail to Meet Federal Standards for Adequate Care, was provided to Mayor Williams and the D.C. Department of Health on November 26, 2001, prior to its public release, in order to give the District government time to prepare a response. On January 7, 2002, Congresswoman Norton officially released the report at a press conference held in conjunction with Mayor Williams and representatives of the Department of Health, who responded to the

report by announcing that D.C. nursing home regulations, which had been held in limbo, would finally be issued. In referring to the District's status as the only jurisdiction in the nation without regulations, Mayor Williams stated at the press conference: "This has got to be unacceptable to me, because it is certainly unacceptable to families of seniors." The Mayor went on to declare: "It's a sin and a crime not to have regulations."

In addition to its promise to immediately publish the nursing home regulations, the Department of Health distributed a document at the press conference, entitled "Initiatives to Improve Quality of Care in District of Columbia Nursing Facilities." In this document, the Department of Health promised, among other things, to:

- create "an enforcement mechanism to compel compliance" through "the use of citations for deficiencies and accompanying civil fines";
- "triple its surveyor staff to meet the need for increased monitoring of nursing facilities";
- further increase the nursing facility survey staff to form "an investigative/ complaint unit";
- develop a Disability and Aging Resource Center to "serve the dual function of empowering consumers to make informed choices about their long-term care options and creating a mechanism to assist in channeling individuals in need of long-term care to the most cost-effective setting";
- establish a "case-mix system" for nursing facility reimbursement by "October 2002"; and
- establish "a unit within MAA/ODA that will focus on continuous quality improvement," by "organizing and supplying training to providers and staff to improve the quality of care."

However, in the fall of 2003, almost two years after the District government assured its citizens that it was working to improve nursing home quality, the Ombudsman Program found that the D.C. Department of Health had failed to follow through on its promises:

- No implementation or enforcement of the District's January 2002 nursing home regulations had occurred.
- The surveyor staff was not tripled and no further increases in survey staff sufficient to form an investigative/complaint unit had occurred.

- Not one deficiency had been cited and not one penalty had been imposed against a nursing home on the basis of the January 2002 regulations.
- No Disability and Aging Resource Center has been developed.
- No case-mix system had been implemented.

In addition, an updated report by the Government Reform Committee of the U.S. House of Representatives on D.C. nursing home care, released by Congresswoman Norton on October 31, 2003, found that the quality of care in the District had not improved in the two years since its previous report was prepared and that serious problems continued to affect the health and welfare of D.C. nursing home residents.

In response to the Department of Health's inaction in implementing its 2002 initiatives and to the Congressional Report's findings of continued serious problems with care in the District's nursing facilities, the D.C. Long-Term Care Ombudsman Program issued "Broken Promises: An Interim Assessment of the District of Columbia's Initiatives to Improve Quality of Care in Nursing Facilities, 2002-2003." The goals of "Broken Promises" were to motivate positive change in the District's enforcement process, to recommend changes designed to improve care, and to stimulate action on the Department of Health's promised initiatives by providing a candid assessment of the District's performance in implementing the steps announced in January 2002 to improve nursing home care. Sadly, "Broken Promises" concluded that the District government had failed "to take its promises seriously and provide the leadership and funding necessary to fulfill them." At the same time, the Ombudsman Program issued its own promise to continue evaluating and assessing the progress made by the District government in implementing the 2002 initiatives and to issue another report if necessary.

In May 2005, "in response to Congresswoman Eleanor Holmes Norton's report on the quality of care provided in Nursing Facilities (NF) in the District of Columbia (District) released October 31, 2003," the D.C. Department of Health issued a second set of initiatives to improve D.C. nursing home care.[1] Similar to the initiatives issued in January 2002,[2] these "new"

---

[1] "Initiatives to Improve Quality of Care in District of Columbia Nursing Facilities," prepared by the District of Columbia Department of Health, Medical Assistance Administration in Coordination with the Health Regulation Administration, May 2005, p.2.

[2] See p.3 above.

initiatives, according to the Department of Health, were designed "to address quality concerns" and reflect "recommendations from the Institute of Medicine (IOM),"[3] as follows:

- "Increasing survey efforts, especially for chronically poor performers, and increasing penalties for noncompliance"
- "Developing programs to disseminate information to consumers on the various types of long-term care settings available top them and the quality of individual providers"
- "Adjusting Medicaid reimbursement formulas for Nursing Facilities to take into account quality requirements and casemix-adjusted needs of residents"
- "Providing targeted training to address potentially problematic care trends and at-risk individuals"

However, based on the D.C. Long-Term Care Ombudsman Program's monitoring and assessment of the quality of care in the District's nursing homes from the end of 2003 through 2005 and of the steps taken and not taken by the D.C. Department of Health to fulfill its promises to improve long-term care in the District, this current report, "Broken Promises II," finds that the District's implementation of its May 2005 initiatives falls as short of success as its implementation of basically the same initiatives promised in January 2002.

II. APPROACH

Under federal law, the U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services (CMS),[4] contracts with the District of Columbia's Department of Health, Health Regulation Administration (DOH, HRA), to conduct annual inspections of nursing homes and to investigate nursing home complaints. Through the use of the federal nursing home survey tool, known as the 2567 survey report, these inspections assess whether nursing homes are meeting the federal standards of care mandated for nursing homes to be certified for Medicaid and Medicare certification. These standards include providing appropriate staffing levels to meet the residents' medical and psychosocial needs, maintaining an environment that is safe and secure, preventing injuries and accidents, and protecting residents' rights, including their right to be free from abuse and neglect. Under state nursing home regulations, including those issued by the District in 2002, nursing homes must also meet the

[3] DOH May 2005 "Initiatives," pp.6-9.
[4] Previously known as HCFA, the Health Care Financing Administration.

federal standards of care, but may have to meet higher standards in areas that a state decides is critical to safeguarding its nursing home residents.

Much like the D.C. Department of Health's Health Regulation Administration, the Office of the D.C. Long-Term Care Ombudsman, as mentioned above, is also federally and locally mandated to monitor, investigate, and work to resolve complaints about poor quality of care and quality of life in the District's nursing homes. The Office of the D.C. Long-Term Care Ombudsman fulfills its mandate through its Ombudsman staff and volunteers, who visit the District's nursing homes on a daily basis both to monitor care and investigate complaints received from residents, family and friends of nursing home residents, nursing home staff, community social workers and healthcare workers, and the general public. The Office of the D.C. Long-term Care Ombudsman collects and enters into its data system via a software program, OmbudsManager, all complaints received, all reports of monitoring visits and investigations conducted by Ombudsman staff and volunteers, and all referrals made by the Ombudsman Program to the Department of Health, Adult Protective Services, law enforcement, Medicare and Medicaid Fraud and Abuse agencies, etc., for further investigation and enforcement action.

Through OmbudsManager, the Ombudsman Program has reviewed and compared complaints reported to and investigated by Ombudsman Program staff and volunteers from 2003 through 2005.[5] The Ombudsman Program staff compared the most recent nursing home survey data (2003 – 2005) with the past "Broken Promises" data (2002 – 2003) in order to document any complaint trends over the past two years.

In addition, the Ombudsman Program has reviewed and analyzed the nursing home survey inspection reports (Federal 2567 reports) completed by the D.C. Department of Health's Health Regulation Administration during the past two years and the nursing home surveys conducted by the Health Regulation Administration under the District's 2002 nursing home regulations. The Ombudsman Program has also reviewed the 2004 and 2005 cumulative complaints reported to the Ombudsman Program, examining the most recent information pertaining to 13 out of 20 nursing homes in Washington, D.C. [6] Finally, the Ombudsman

[5] All of the 2005 D.C. DOH, HRA survey data for the 13 nursing homes that the Ombudsman Program selected for review was not available during the research and drafting period of this report. The Ombudsman Program has used available data from Calendar Years 2003, 2004, and the first half of Calendar Year 2005 to produce this report

[6] The thirteen nursing homes analyzed to create this report were chosen at random.

Program has compared the District's promised initiatives to improve quality of care – first presented in 2002 and then reissued with slight variation in May 2005 -- with the progress actually made in implementing these initiatives through reports and testimony to the City Council and first-hand experience collected through complaints made to the Ombudsman Program.

While the findings are representative of patterns of care and services received by residents of the District's nursing homes, conditions in individual nursing homes can change, and usually do, when new management or focused enforcement activities are conducted. For this reason, this report should be considered a snapshot in time of the nursing home care and enforcement activities that have emerged in the past two years.

III. FINDINGS

Overall, the Ombudsman Program has found that the Department of Health has not followed through on its promises, the outcomes of which remain uncertain. To date, the following remain true:

- Monitoring and regulation of the District's nursing homes for violations of Federal nursing home regulations have not improved due to the continued under-rating of nursing facility deficiencies and the failure to impose civil monetary penalties and other sanctions under federal guidelines;
- While the number of notices of infractions cited by HRA under the District's nursing home regulations has increased, the monetary fines imposed on nursing homes has not increased;
- A Disability and Aging Resource Center has been established, but it has not been fully funded and thus, has not been able to fulfill its original mandate of providing elderly and disabled residents with alternatives to nursing home care;
- A workable case-mix Medicaid payment methodology system for nursing facilities has not been fully implemented city-wide as promised, and;
- While the need for improved training of nursing home staff has been acknowledged, no new programs have been implemented that would improve services and increase the quality of care for D.C. residents.

A. INITIATIVE TO IMPROVE NURSING HOME ENFORCEMENT

1. Increasing Staff and Penalties

As noted earlier, in its January 2002 "Initiatives to Improve Quality of Care in District Nursing Facilities," the D.C. Department of Health promised to:

- create "an enforcement mechanism to compel compliance" through "the use of citations for deficiencies and accompanying civil fines"
- "triple its surveyor staff to meet the need for increased monitoring of nursing facilities"
- further increase the nursing facility survey staff to form "an investigative/ complaint unit"

In its May 2005 "Initiatives to Improve Quality of Care in District Nursing Facilities," the D.C. Department of Health presented as its first initiative:

- "Increasing survey efforts, especially for chronically poor performers, and increasing penalties for noncompliance."

To date, however, these goals have not been achieved.

Although the Department of Health's Health Regulation Administration (HRA), in December 2003, finally began to survey nursing facilities for deficiencies and to issue citations under the 2002 D.C. nursing facility regulations, its surveyor staff has not been tripled and "an investigative/complaint unit" has not been formed. **Since 2002, the number of HRA nursing home investigators on staff has fluctuated between five and seven; the current number of survey/complaint investigation staff is four.** It is, therefore, not surprising that the average response time by HRA to complaints filed by the Ombudsman Program in 2005 was **4.5 months** and that survey efforts, especially for chronically poor performers, and penalties for noncompliance have not increased.

In its May 2005 report, HRA stated that "most District NF's were found to be in substantial compliance with local nursing home regulations" in 2004, yet the report goes on to say that more than half (55%) had deficiencies with the potential to harm residents and 45% had deficiencies causing actual harm to residents.[7] In addition, in 2004, the Ombudsman Program logged **1296 complaints about nursing facility care**; and in 2005, after the number of nursing homes in the District decreased from 21 to 20, the Ombudsman Program received **1675 complaints about**

[7] DOH May 2005 "Initiatives," p.5.

care and services.[8] Further, although the Health Regulation Administration issued an average of 12.8 deficiencies per facility for 2003, and an average of 18.2 deficiencies per facility for 2004,[9] no federal monetary penalties or other sanctions have been imposed for these deficiencies since April 3, 2003.[10]

Despite the large numbers of complaints about nursing home care received by the Ombudsman Program in 2004 and 2005, fourteen nursing homes were issued 25 notices of infraction for only 34 violations of D.C. regulations, from December 2003 through December 2004, resulting in the collection of $16,740.60 in monetary fines, with $8,580 in monetary fines unpaid or pending in court.[11] From January 2005 through December 2005, eleven nursing homes were issued 26 notices of infraction for 39 violations, resulting in the collection of $10,110 in fines, with $11,425.00 unpaid/uncollected.[12] Although in 2004 and 2005, the Ombudsman Program received a total of 2,971 complaints from residents, family and friends of residents, ombudsman volunteers, nursing home and hospital staff, social workers, and others about the care and services being provided in the District's nursing homes, from December 2003 through December 2005, nursing facilities in the District paid a total of only $26,850.60 in fines for only 73 cited violations of D.C. nursing facility regulations -- an average of $367.82 per violation, many of which, as this report illustrates, posed a threat of harm to residents or actually resulted in harm.

---

[8] Medstar Manor closed in the spring of 2004.

[9] *Cf.* Charlene A. Harrington, Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1998 – 2004. Department of Social and Behavioral Sciences, University of California, San Francisco, August 8, 2005. Note: Charlene A. Harrington, Ph.D., R.N., F.A.A.N., Professor of Sociology in the Department of Social and Behavioral Sciences at the University of California, San Francisco, has served as Principal Investigator of several national long-term care research studies including the five-year National Evaluation of the Social/Health Maintenance Organizations (S/HMO) Demonstrations Projects for HCFA. Her areas of expertise include health care financing, legislation, policy analysis, and regulation and planning.

[10] *Cf.* On HRA's website (http://doh.dc.gov/doh/cwp/view,a,1374,q,577174,dohNav_GID,1840.asp), the last monetary penalty imposed against a nursing home under federal survey guidelines $4,875 against Hadley Skilled Unit. Requests to HRA and FOIA requests to CMS for a list of monetary penalties imposed on D.C. nursing facilities for violations of federal nursing facility regulations from April 2003 through December 2005 have been ignored. Since this information is supposed to be available to the public on HRA's website, as well as provided to the D.C. Long-Term Care Ombudsman Program under its Memorandum of Agreement with the D.C. Department of Health, the Ombudsman Program can only conclude that no monetary penalties for violations of federal nursing home regulations have been imposed by CMS since April 2003.

[11] This information was provided to the Ombudsman Program by the D.C. Department of Health on June 13, 2005.

[12] This information was provided to the Ombudsman Program by the D.C. Department of Health, Health Regulation Administration, on Feb. 16, 2006.

In its November 2003 "Broken Promises" report, the D.C. Long-Term Care Ombudsman Program took the Department of Health to task for imposing no monetary penalties for violations of D.C. nursing facility regulations and recommending only $42,732.50 in civil monetary penalties between January 2002 and October 2003 for violations of federal nursing home regulations. Yet, the D.C. Department of Health, after promising, in January 2002, to increase survey and complaint investigation staff, and in May 2005, to increase penalties for noncompliance, imposed considerably less in monetary penalties for deficient nursing care under District nursing facility regulations between December 2003 and December 2005 than it did under federal regulations between January 2002 and October 2003. In addition, there is no indication that penalties or sanctions other than monetary fines -- such as licensure restrictions and withholding of payment -- have been imposed against substandard facilities during 2003-2005.

Without the imposition and collection of **serious federal and District** monetary penalties for substandard and life-threatening care, poor performing nursing homes have little incentive to improve their services or change their methods of operation. Given the fact that the highest fine imposed by HRA for a violation was $2,860 and that, for the majority of violations, fines under $1,000 were imposed, the District's enforcement system encourages nursing facilities to simply pay the fine and continue the substandard performance that led to the fine, because fixing the problems resulting in harm to residents, such as hiring sufficient direct care staff, would cost many times more than even the highest fine. The result is that residents remain victims of poor care as the same violations are repeated year after year in the same facilities without correction.

2. Increasing Survey Efforts

In its November 2003 "Broken Promises" report, the D.C. Long-Term Care Ombudsman Program criticized the D.C. Department of Health for lax enforcement of federal nursing facility standards, as well as for failing to implement the D.C. nursing facility regulations that were issued in January 2002. Since then, as of December 2003, HRA began to cite nursing homes for violations of the D.C. nursing facility regulations. However, as noted above, the monetary penalties under D.C. regulations are minimal,[13] do not reflect the seriousness of many of the

[13] The schedule of fines for infractions of the D.C. nursing facility regulations go from $50 for a Class 5 infraction to $2,000 for a Class 1 infraction. 16 DCMR §3201.1 *et seq.*

violations, and will not deter nursing facilities from continuing to provide substandard care. One of the barriers to improving care continues to be HRA's interpretation and application of the D.C. nursing home regulations to violations. 16 DCMR 3201.2 states: "[a]n infraction shall be a repeat infraction and shall carry the enhanced penalties set forth in §3201.1." Yet, the Ombudsman Program, in its review of two fiscal years beginning in October of 2003 and ending in September of 2005, found not one citation that was labeled "enhanced" by HRA or recommended for daily compound fines.

In addition, the Ombudsman Program continues to have questions about the validity and quality of the nursing home surveys that HRA performs for CMS. These concerns are due not just to the apparent absence, since April 2003, of monetary fines or other sanctions imposed for violations of federal nursing facility standards, but also to continued under-rating by HRA surveyors of the scope and severity of deficiencies in District nursing homes.

As explained in the November 2003 "Broken Promises," under the federal nursing home regulatory system, every state and the District of Columbia has a contract with the Centers for Medicaid and Medicare Services (CMS), U.S. Department of Health and Human Services, to survey all nursing homes that receive Medicaid or Medicare funding to ensure compliance with minimal standards of care set by the Omnibus Reconciliation Act of 1987 (generally known as OBRA'87) and by the Nursing Home Reform Amendments of 1990. In the District, the Department of Health's Health Regulation Administration (HRA) is the agency funded by CMS to conduct surveys of District nursing homes to determine whether or not they meet federal standards of care. Surveyors use the following scope and severity grid developed by CMS to rate deficiencies:

Assessment Factors used to Determine

The Seriousness of Deficiencies Matrix[14]

Immediate jeopardy to resident health or safety	**J** [redacted] PoC [redacted] Required: Cat. 3 Optional: Cat. 1 Optional: Cat. 2 [redacted]	**K** [redacted] PoC [redacted] Required: Cat.: 3 Optional: Cat. 1 Optional: Cat. 2 [redacted]	**L** [redacted] PoC [redacted] Required: Cat. 3 Optional: Cat. 2 Optional: Cat. 1 [redacted]
Actual harm that is not immediate	**G** PoC Required: Cat 2. Optional: Cat. 1	**H** PoC Required: Cat 2 Optional: Cat 1 [redacted]	**I** [redacted] PoC [redacted] Required: Cat. 2 Optional: Temporary Mgmt.
No actual harm with potential for more than minimal harm that is not immediate jeopardy	**D** PoC Required: Cat. 1 Optional: Cat. 2	**E** PoC Required: Cat. 1 Optional: Cat. 2	**F** [redacted] PoC [redacted] Required: Cat. 2 Optional: Cat. 1 [redacted]
No actual harm with potential for minimal harm	**A** [redacted] PoC [redacted] No remedies [redacted] [redacted] Commitment to Correct [redacted] Not on CMS-52567	**B** [redacted] PoC [redacted]	**C** [redacted] PoC [redacted]
	Isolated	Pattern	Widespread

[redacted] Substandard quality of care is any deficiency in 42 CFR 483.13, Resident Behaviors and Facility Practices, 42 CFR 483.13 Quality of Life, or 42 CFR 483.25, Quality of Care, that constitutes immediate jeopardy to resident health or safety; or a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm that is not immediate jeopardy, with no actual harm

[redacted] Substantial compliance

POC: Plan of Correction(s)

Remedy Categories

Category 1 (Cat.1)	**Category 2 (Cat.2)**	**Category 3 (Cat.3)**
Directed Plan of Correction State Monitor; and/or Directed In-Service Training	Denial of Payment for New Admissions Denial of Payment for All Individuals imposed by CMS; and/or Civil money penalties: $50-$3,000/day $1,000-$10,000/instance	Temp. Mgmt Termination **Optional:** Civil money penalties $3,050-$10,000/day $1,000-$10,000/instance

[14] Remedy categories and penalty definitions defining each scope and severity incident is on the following page.

Under CMS Guidelines, "A" violations are simply noted in the Federal 2567 survey reports with no response required from the nursing home. Violations rated from "B" to "F" require the nursing home to do nothing more than submit a plan of correction, although in certain cases (but so far not required in the District), a civil monetary penalty may be imposed for a "D" violation. Whether or not that plan of correction is actually implemented and actually corrects the violation is rarely addressed in the District. It should also be noted that a facility is considered "in substantial compliance" with federal standards if it receives no deficiencies above a "C," (please refer to grid on the previous page) regardless of how many "A," "B," and "C" deficiencies are cited. Any violation rated a "G" or above may be recommended by the HRA for a civil monetary penalty in addition to a plan of correction. Other remedies are possible for deficiencies rated "G" and above, including (for "J" to "L" violations) denial of payment for new admissions, disqualification from Medicare and/or Medicaid payments, and placement of a receiver or temporary manager in the nursing home.

For this report, the Ombudsman Program analyzed the 2003 –2005 nursing home survey reports submitted to CMS by the Health Regulation Administration for 13 of the District's 20 nursing facilities, chosen at random. The Ombudsman Program found that, from December 2003 to September 2005, eight of the thirteen facilities had been cited for 23 deficiencies that caused actual harm to nursing home residents, including fractured limbs not properly assessed by staff, preventable accidents, medication administration errors, and failure to report unusual incidents to the appropriate authorities. HRA rated 22 of these deficiencies at the "G" level. However, the Ombudsman Program has not found any evidence that the nursing homes cited received any federal monetary penalties or other sanctions. Further, in analyzing the deficiencies described in the survey reports for the thirteen facilities it reviewed, the Ombudsman Program staff found 49 that they would have rated at a higher scope and severity level than HRA rated them.

Admittedly, this problem of under-rating is not confined to HRA. A recent Government Accountability Office report (GAO-06-117), entitled "Nursing Home Quality and Safety Initiatives," found that States fail to accurately report the injury and harm that nursing homes **affirmatively cause harm** to residents, that the agency contracted to survey the State's nursing homes (e.g., HRA in the District) "allows homes to conceal problems...," and that "state inspections ... understated the extent of serious quality-of-care problems, reflecting ... inconsistent application of federal standards." The report also found that "[n]ursing homes

repeatedly caused **actual harm** to residents, such as worsening pressure sores or untreated weight loss, or placed residents at **risk of death or serious injury**" and that "**serious complaints** by residents, family members, or staff alleging **harm** to residents remained **uninvestigated for weeks or months**...." [15] Finally, the report states that CMS acknowledges that (1) nursing home State surveys under-rate what inspectors find and report by 8 to 33 percent, and (2) there is an "increase in such discrepancies [between what a State admits and what CMS finds when it surveys the same nursing homes] from 22 to 28 percent." Clearly, when violations of care standards under the federal system are under-rated, federal penalties or sanctions are not imposed and poor performing nursing homes continue to put residents at risk of injury and even death. While under-rating of deficiencies is a problem nationwide, HRA continues to be part of that problem. The following pages provide some examples of the ratings issued by HRA for deficiencies identified in nursing home surveys performed for CMS during 2003-2005. The D.C. Long-Term Care Ombudsman Program provides a comment section assessing the ratings given by the HRA to the deficiencies described.

Examples

Violation: Failure to notify a physician after blood was found in the diaper of one resident and failure to notify physician of pressure sore development.
HRA Rating: **D** (isolated incident; potential for more than minimal harm)
Ombudsman Program Rating: **G,** because presence of blood and development of pressure sores reflect actual harm to a resident.

Violation: Failure to monitor a resident's glucose level as ordered by a physician; failure to obtain weekly blood pressure as ordered; failure to give insulin coverage for elevated fingerstick results as ordered; failure to test glucose as well as administer insulin; plus seven other deficiencies in resident assessment.
HRA Rating: **E** (pattern; potential for more than minimal harm)
Ombudsman Program Rating: **H,** because deficiencies affecting 11 of 13 residents sampled indicate widespread harm and failure to monitor the glucose levels of diabetics and provide insulin ordered by a physician put these residents in immediate jeopardy to residents' health and safety.

Violation: Failure to assess a resident for pain complaints during wound care; failure to assess a resident for abdominal pain complaints; failure to follow up on abnormal albumin levels for a resident; failure to obtain weekly blood pressure for resident on Lasix; failure to administer insulin coverage for two residents; failure to assess pressure sore; as well as five other deficiencies in resident assessment.

---

[15] Emphasis added in bold.

HRA Rating: **E** (pattern; potential for more than minimal harm)
Ombudsman Program Rating: **H,** because the deficiencies in medical care were widespread and posed an immediate danger to residents' health and safety.

Violation: Failure to identify stage 3 pressure sore development on leg and failure to promote healing of stage 1 pressure sore on heel of resident; failure to identify stage 3 sacrum pressure sore on resident; failure to follow orders for positioning and use clean technique during wound treatment on a resident.
HRA Rating: **G** (isolated; actual harm to health/safety)
Ombudsman Program Rating: **I,** because the failures of care were found in 3 of five residents sampled and were therefore widespread.

Violation: Failure to obtain K+ levels for resident on Lasix as ordered; failure to follow up on a request for an x-ray for a resident who was later determined to have a fractured hip; along with four other deficiencies in physician services.
HRA Rating: **C** (widespread; no actual harm; facility in substantial compliance)
Ombudsman Program Rating: **F,** because substandard medical care provided to 6 of 30 residents sampled indicates widespread potential harm.

Violation: Hand mitts applied to prevent resident from pulling/eating dressing materials with no evidence that interventions other than physical restraints were used; resident with six falls over four months; three other violations of physical restraints regulations.[16]
Rating: **C** (widespread; no actual harm; facility in substantial compliance)
Ombudsman Program Rating: **F,** because restraint violations have the potential to harm residents and violations for 5 of 30 residents sampled indicates a pattern for potential for harm.

Violation: Dental consultation recommended extraction of two teeth but no follow-up was done and resident had continual pain/facial swelling and poor (food) intake until teeth were finally extracted; no follow-up for post surgical evaluation of resident following emergency surgery for ischemic bowel with obstruction; no follow-up for recommended GYN/ONC appointment for resident found to have cancer in pelvis; improper transcription of order for Prosource for resident with low albumin, none received for a month and improper lower amount given for a month; no psychiatric consultation obtained for five months despite social service urgent recommendation for resident subsequently started on antidepressant and dementia medications; no chart record of metabolic panel drawn five months earlier for resident found to have blood sugar of 233mg/dL

---

[16] HRA claims in its 2005 "initiatives to Improve Quality Care in the District of Columbia," cited *supra* (p.6), that "[t]he District has strict regulations regarding the use of restraints." However, the current District regulations regarding the use of physical and chemical restraints do not comply with Federal regulations and do not go far enough to eliminate the abuse of physical and chemical restraints. For example, 22 DCMR §3216.1 simply states, "[e]ach resident has the right to be free from unnecessary physical and chemical restraints." Because "unnecessary" is not defined in the regulations, the term is open to interpretation by the nursing facility. In contrast, the federal regulation, 42 CFR § 483.13(a) states, "[t]he resident has the right to be free from any physical or chemical restraint imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms." The federal regulations are more restrictive and thus, more protective against abuse. In addition, DCMR §3216.4 allows for a registered nurse to administer restraints in emergency situations in violation of federal regulation 42 U.S.C. 1396r (c)(1)(A)(11), which clearly states "only physicians can order physical or chemical restraints" (emphasis added).

and started on oral hypoglycemic; coumadin order transcribed incorrectly and no evidence it was given for a period of twelve days in February; eighteen other deficiencies in resident assessment and quality of care.
HRA Rating: **G** (isolated; actual harm to health/safety)
Ombudsman Program Rating: **L,** because serious deficiencies in medical care for 18 of 30 residents sampled and 5 of 20 supplemental residents sampled indicate that the health and safety of residents in this nursing facility were in widespread and immediate danger.

Violation: Insufficient nursing staff to implement professional standards of care, resulting in the deficiencies directly above.
HRA Rating: **E** (pattern; potential for more than minimal harm)
Ombudsman Program Rating: **L**, because serious deficiencies medical care for 18 of 30 residents sampled and 5 of 20 supplemental residents sampled indicate that the health and safety of residents in this nursing facility were in widespread and immediate danger as a direct result of the lack of staffing.

Violation: X-ray performed 24 hr. after resident exhibited abdominal pain/vomiting showed small bowel obstruction, yet another 24 hr. lapsed with no treatment or evaluation by attending physician evaluation by attending physician or member of medical team at nursing facility or member of medical team; on 3rd day after vomiting began, resident was admitted to the hospital for emergency bowel resection; these and 6 more deficiencies in physician services found.
HRA Rating: **G** (isolated; actual harm to health/safety)
Ombudsman Program Rating: **J**, because resident requiring bowel resection for obstruction following three days of vomiting/pain with out a medical evaluation was in immediate jeopardy.

Violation: Nine wheelchairs soiled on three floors; twelve exhaust vents dirty on four floors; twenty-six doors soiled/marred throughout building; floors sticky and not clean in eight rooms; personal items stored in disorderly manner in storage rooms; walls damaged behind beds in nine rooms; soiled linen rooms; ceiling tiles stained/ill-fitting in sixteen areas; baseboards separated from wall surfaces; strong urine odors in area around two rooms; water accumulated on floor following shower; window sills damaged in six rooms; improper use of clothes dryers, and other environmental deficiencies.
HRA Rating: **E** (pattern potential for more than minimal harm)
Ombudsman Program Rating: **F**, because deficiencies were widespread throughout the facility.

Violation: Delay of twenty-four hours in transporting a resident, with a temperature of 104 to the emergency room.
HRA Rating: **G** (isolated; actual harm to health/safety)
Ombudsman Program Rating: **J**, because this failure in care posed an immediate danger to the resident's health.

Violation: Failure to investigate hospital acquired infections, no tracking reports to determine mode of transmission, failure to analyze data pertaining to urinary tract infections.
HRA Rating: **D** (isolated incident; potential for more than minimal harm)
Ombudsman Program Rating: **H,** because unsanitary practices affect all residents in the facility.

Violation: Failure of dentist to perform follow up visit on a resident with pain/decaying teeth whose tooth subsequently broke off.
HRA Rating: **D** (isolated incident; potential for more than minimal harm)
Ombudsman Program Rating: **G**, because actual harm, the loss of the tooth, was a result of deficient dental services.

Violation: Failure to provide adequate supervision for resident with a history of seizures and unsteady gait who fell in room, resulting in emergency transfer to hospital for bruises and unresponsiveness.
DOH/HRA Rating: **D** (isolated incident; potential for more than minimal harm)
Ombudsman Program Rating: **G,** because the resident suffered actual harm and injury as a result of this deficiency in care.

Violation: Failure to assess/identify a fractured elbow for 3 days while resident complained of pain/yelled/grimaced, exhibited swelling/bruising; x-rays inaccurately interpreted and blood tests ordered by physician for that resident failed to be performed; failure to insert suprapubic catheter/wrong size inserted for a resident; as well as seven other deficiencies in resident assessment and quality of care.
HRA Rating: **G** (isolated; actual harm to health/safety)
Ombudsman Program Rating: **H or I**, because deficiencies show at least a pattern of poor care and possibly widespread poor care resulting in actual harm to residents.

Violation: Call Cell Boxes in shower lacked plastic covers, have damaged/broken switches and are missing pull cords on three floors.
HRA Rating: **C** (widespread; no actual harm; facility in substantial compliance)
Ombudsman Program Rating: **F**, because residents' inability to alert staff of an emergency in the shower room has the potential for more than minimal harm and affects all residents who shower in that facility.

Violation: Failure to provide adequate assistance during transfer of resident from bed to chair resulting in elbow fracture for a resident whose Minimum Data Set (MDS)[17] stated the resident required at least 2 persons for physical assistance with transfers; another resident who has physical functioning/structural problems and requires at least 2 persons for transfer fell during transfer from bed to shower chair.
HRA Rating: **G** (isolated; actual harm to health/safety)
Ombudsman Program Rating: **H,** because if this failure occurred with two of the sampled residents, a pattern of actual harm is indicated.

[17] The federal government requires that nursing homes receiving Medicaid and Medicare funds prepare a comprehensive assessment, known as the Minimum Data Set (MDS), for every resident upon admission to the nursing home and periodically thereafter. The MDS assessment of the resident's medical, social, psychiatric, nutritional, and functional status is then used to determine the resident's care needs and to create a plan of care to meet those needs.

Violation: Resident twice physically assaulted, hit in face, by another resident with history of prior assaults; another resident hit in head by another resident with wheelchair pedal, laceration required 9 staples.
DOH/HRA Rating: **G** (isolated; actual harm to health/safety)
Ombudsman Program Rating: **H**, because incidents show pattern of harm.

Violation: Resident assessed as "no problems with behavior" despite three episodes-- throwing coffee at nurse aide, hitting another resident in head four times with a cane, and striking another resident in the leg with a cane.
HRA Rating: **D** (isolated incident; potential for more than minimal harm)
Ombudsman Program Rating: **I**, because actual harm was caused and resident engaged in a pattern of harmful behavior without appropriate intervention by nursing facility.

Violation: Fracture of resident's tibia/fibula when nursing assistant used wrong lift to transfer resident; 11 of 30 residents sampled and 8 of 10 supplemental residents experienced basic deficiencies in care.
HRA Rating: **G** (isolated; actual harm to health/safety)
Ombudsman Program Rating: **I**, because widespread failure in care was found.

As in "Broken Promises 2002 -2003," this report finds that HRA's regulatory enforcement is not strong enough to ensure that serious deficiencies are corrected and repeat poor performers are deterred from providing substandard care and services to the District's nursing home residents.

3. Increasing Monitoring of Poor Performers

From its analysis of the Health Regulation Administration's surveys, the Ombudsman Program found that another major reason for the lack of progress in improving nursing home care is the ineffective monitoring by HRA of plans of correction provided by the nursing homes in response to deficiency citations. The Ombudsman Program has seen plans of correction that are almost indistinguishable from year to year for the same deficiencies in the same nursing homes.[18] As the Ombudsman program has repeatedly argued, it is critical that a nursing facility be given a specific and reasonable date by which to correct the violations found by HRA and that an inspector be assigned to reinspect -- and be held accountable for reinspecting -- by the

[18] Between December 2003 and December 2005, for example, one nursing home was cited for the same violations in February and April 2005 and for another same violation in January, March, August, and November 2005; another nursing home was cited for the same violation in July and October 2004 and another same violation in January and March 2005; a third nursing home was cited for the same violation in June 2004, July 2004, and August 2005 and for another same violation in April and August 2005; two other nursing homes were cited for the same violation in successive months.

required date. In addition, HRA must issue compound fining of a facility for the repeat offenses that are not corrected by the date(s) specified. The following examples illustrate deficiencies that were described in "Broken Promises 2002-2003" and found to be recurring during the 2003-2005 surveys without correction:

Violation: Inadequate care plans to provide for resident's needs, e.g., no plan to monitor elopement for resident with dementia; no plan to prevent resident from wandering into room of another who had history of physical aggression towards that resident; medications discontinued and begun for a resident without precautions for medications documented; failure to document that resident's position was to be changed every two hours to prevent worsening of pressure ulcer(s); failure to plan interventions for behaviors of resident resisting care.
Plan of Correction: Update resident care plans; monitor residents; assess care plans.
Comment: 13 of the 13 nursing home surveys reviewed for this report contained similar, if not identical deficiencies in resident care plans as those noted "Broken Promises, 2002-2003."

Violation: Hot water valves/pumps not operating effectively; hot water is too cold, e.g., 84-98 degrees F., 78-108 degrees F., 68-100 degrees F. instead of the 110 degrees F. required for baths/showers.
Plan of Correction: Inspected system to determine replacement needs.
Comment: This deficiency was noted in "Broken Promises, 2002-2003," so the inspection plan failed to lead to correction.

Violation: The facility failed to provide necessary care and services as evidenced by the failure to administer insulin when a resident's blood sugar levels required insulin to be given and failure to provide the correct dose of insulin on two occasions.
Plan of Correction: Prepare insulin error report.
Comment: This deficiency was noted in "Broken Promises, 2002-2003," so the plan of correction either failed to correct the problem or was never implemented. Additionally, all 13 homes reviewed for this report were cited for deficiencies in providing correct dosages of medicine to residents and in administering medicine and medical procedures as ordered/required, putting residents' health in jeopardy.

Violation: Failure to comply with the Life Safety Code Standard to ensure resident safety in the event of a fire, e.g., failure to document fire alarm system testing, failure to ensure that double doors locked and closed to prevent the passage of smoke in the event of a fire, smoke barrier walls above ceiling tiles not in good condition to prevent passage of smoke.
Plan of Correction: Check and replace deficient fire doors.
Comment: This deficiency was noted in "Broken Promises, 2002-2003," so the plan of correction either failed to correct the problem or was never implemented. Additionally, this deficiency was cited for 9 nursing facilities in 2003-2004, and a number of facilities have been cited for this deficiency every year from 2002 to 2004.

B. INITIATIVE TO DEVELOP AGING & DISABILITY RESOURCE CENTER

In 2002, the D.C. Department of Health's Medical Assistance Administration (MAA) was successful in receiving $2.1 million dollars in federal grant funds to develop home and community based services waiver programs and an Aging and Disability Resource Center in the District. These programs are designed to provide elderly and disabled persons with options to receive long-term care services at home or in a community-based residence instead of in a nursing home. The then-Director of MAA recognized that many States had for years been developing one-stop long-term care service centers and related programs to keep the elderly and persons with disabilities at home and independent as long as possible, not only to improve their quality of life but also to save on the enormous and ever rising costs of nursing home care. The District, in contrast, has provided these residents with little or no alternative to institutionalization for long-term care.

In its January 2002 "Initiatives to Improve Quality Care in District of Columbia Nursing Facilities," then, the D.C. Department of Health promised to develop a Disability and Aging Resource Center to "serve the dual function of empowering consumers to make informed choices about their long-term care options and creating a mechanism to assist in channeling individuals in need of long-term care to the most cost-effective setting." However, the Ombudsman Program noted in its 2003 "Broken Promises" report, that as of November 2003, MAA had failed to create the Resource Center and to fully implement the home and community based Medicaid waivers to assist the elderly and disabled.

In its May 2005 "Initiatives to Improve Quality Care in District of Columbia Nursing Facilities," the D.C. Department of Health again listed as its second major initiative: 'Developing programs to disseminate information to consumers on the various types of long-term care settings available to them and the quality of individual providers." DOH went on to repeat the statements in its January 2002 report that the Center "will serve the dual function of empowering consumers to make informed choices about their long-term care options and creating a mechanism to assist in channeling individuals in need of long-term care to the most cost-effective setting" through a "comprchensive interdisciplinary program" of "screening and assessment and counseling services" to ensure that D.C. residents needing long-term care will have options other than institutionalization. However, the District Aging and Disabilities Resource Center that began operations in December 2004 lacked the funding that CMS had

previously approved and granted. Because the funding had been substantially reduced, the Center has lacked the resources to provide the services originally envisioned.

Consequently, despite DOH's claims in its January 2002 and May 2005 reports about the services and options that the Center would and had provided, a D.C. Council task force[19] reported in December 2005 that the District "has failed to use available federal funds to keep elderly residents out of nursing homes, spends disproportionate dollars on institutional care instead of home and community support, and . . . has a regulatory system that does not assure that these vulnerable people will receive high-quality services no matter what the setting."[20] In particular, the 17-person task force's report focused on "the confusion and the paucity of information" that limits the options of the elderly and persons with disabilities and results in their "unnecessary placement" in institutional care, and it called for "much more public outreach and coordination among professionals."[21] The failures found by the D.C. Council task force are those that the Center was developed to correct, and the recommendations made in the report are those that the Ombudsman Program and other aging and disability advocates have been requesting since 2003.

C. INITIATIVE TO ESTABLISH A CASEMIX SYSTEM

In its January 2002 "Initiatives to Improve Quality Care in District of Columbia Nursing Facilities," the D.C. Department of Health stated as its third major initiative: "Adjusting Medicaid reimbursement formulas for Nursing Facilities to take into account quality requirements and casemix-adjusted needs of residents" by October 2002. In discussing implementation of a casemix system, DOH went on to say that it "has recognized that the current methodology the District uses to establish Medicaid rates for nursing facilities fails to encourage quality care, especially for the most vulnerable District residents," that the current rate methodology acted as "a barrier to the provider ability to give adequate care for individuals with greater needs," and that the current rate "creates a strong incentive" to keep individuals in nursing homes who could potentially be served through home and community based services.

---

[19] Jerry Kasunic, Director of the D.C. Long-Term Care Ombudsman Office, served on the task forces for both the Access and Quality of Care Subcommittees.
[20] Susan Levine, "Panel Urges Changes in Elderly Care," *The Washington Post,"* December 1, 2005, District, p.3 .
[21] *Ibid.*

Despite DOH's recognition of the problems with its current nursing home payment system, by November 2003, when the Ombudsman Program issued its first "Broken Promises" report, a casemix system of nursing home reimbursement had not been implemented.

In its May 2005 "Initiatives to Improve Quality Care in District of Columbia Nursing Facilities," the D.C. Department of Health again presented establishment of a casemix system as its third initiative, repeating word for word the comments that appeared in the January 2002 "Initiatives" about the problems with the current system and the advantages of the casemix system. The only difference between the two discussions of this initiative is that in the May 2005 report, the implementation date for the new casemix system was given as "Summer 2005," rather than "October 2002." However, to date, the D.C. Department of Health and the City Council has passed legislation (January 2006) in order to create and implement a casemix system, but casemix has yet to be fully implemented and providers, presumably, continue to lack encouragement to provide quality care. [22]

D. INITIATIVE TO PROVIDE TRAINING TO IMPROVE QUALITY OF CARE

In both its January 2002 and May 2005 "Initiatives to Improve Quality Care in District of Columbia Nursing Facilities," the D.C. Department of Health listed as its fourth initiative: "Providing targeted training to address potentially problematic care trends and at-risk individuals." Both reports stated, "To achieve this goal, DOH is seeking funds to accomplish the following goals," which in both reports include: (1) Establishing a unit within the D.C. Medical Assistance Administration's Office on Disability and Aging that will, among other things, "focus on continuous quality improvement" by "proactively identifying individuals potentially at risk," "working to ensure that plans of correction are implemented and resident outcomes improved"; (2) Providing training to providers and staff "to improve the quality of care"; and (3) Extending the Delmarva Foundation's[23] scope of work to include "additional training targeted to providers for whom quality concerns have been identified. The fact that the same goals are stated in exactly the same words in DOH's 2002 and 2005 "Initiatives" clearly demonstrates that no

---

[22] Changes were made to the proposed casemix system in the Notice of Final Rulemaking, February 24, 2006 amending 29 DCMR 6500 (53 DCR 1350), but no clear acuity definitions and reimbursement processes has occurred.

[23] The D.C. Department of Health contracts with the Delmarva Foundation to assess an individual's initial and continuing medical eligibility for nursing home services under Medicaid/Medicare.

progress was made by DOH in implementing the goals of this initiative between January 2002 and May 2005.

Nevertheless, in its discussion in its 2005 report of its first initiative for improving quality care, i.e., increasing survey efforts, DOH mentions that it had recently restructured its contract with the Delmarva Foundation "to include a significant quality improvement component." As explained by DOH, Delmarva Foundation now validates the MDS data[24] self-reported by nursing homes "by comparing it to independent resident assessments and medical record reviews and identifying clinical flags that could suggest a quality concern." If a resident is flagged by this method, "a Delmarva review nurse will conduct an in-person assessment and medical record review" followed by a report to MAA, which "will then determine whether to work with the facility to address the concern or to forward it to the Health Regulation Administration (HRA) for sanction."

While supporting DOH's initiatives to improve nursing home care, the Ombudsman Program has concerns about the value to be derived from the expenditure of funds for Delmarva's added duties, as described above. To begin with, a recent report for the National Commission for Quality Long-Term Care[25] notes that "the use of the MDS outcome-based data for ranking and comparing facilities is still controversial" and that researchers have had concerns about the Outcome-Based Quality Indicators (OBQI) approach to quality assurance, on which the MDS is based -- in particular, its validity and reliability in practice, i.e., in "real world" situations.[26] The report goes on to say that researchers have found not only that "the relationship between quality indicators and quality care is too complex to be captured in the MDS" but also that "there may be perverse incentives and counterproductive conclusions drawn from MDS data and associated QIs [Quality Indicators]."[27] Further, the report states that little evidence exists to

---

[24] The MDS, or Minimum Data Set, is the tool that CMS requires nursing homes to use to assess residents when they enter a nursing home to determine their functional, physical, mental, nutritional, recreational, and psychosocial needs. The resident's plan of care is then developed from the MDS data.

[25] John Capitman, et al., "Long-term Care Quality: Historical Overview and Current Initiatives," National Commission for Quality Long-Term Care, 2005 (http://www.qualitylongtermcarecommission.org/reports).

[26] Similarly, in an article in the September 2005 issue of *The Gerontologist,* three prominent researchers at the Borum Center of Gerontological Research at UCLA concluded that direct observation of care delivery should be adopted as a means of evaluating nursing home quality because observational data "provide one of the few sources of information about care that is independent of staff self-reports" which are often filled with inaccuracies. The MDS is the primary self-reporting tool used by Delmarva to measure nursing home quality.

[27] A study of the uses of the MDS indicated that the better facilities are at evaluating and documenting care problems, the worse the facilities may appear on the QI scale. For example, nursing homes rated as having high

directly link "the implementation of MDS to patient outcomes and satisfaction," and that sharing data on QI performance with providers "does not necessarily lead to improvements in care processes." Finally, the report points out that the medical approach of the MDS system fails to include "attention to patient autonomy and quality of life"; instead it "makes specific tasks and avoidance of mistakes the focus of facilities, rather than the needs and wants of individual people in their care."

In addition to concerns that resident care will not be improved as a result of Delmarva's enhanced focus on the MDS, the Ombudsman Program also believes that any positive outcomes for residents that could result from Delmarva's new tasks will be diminished by Delmarva's lack of cooperation with the Ombudsman Program and other long-term care advocates and failure to communicate its findings to these groups to better protect long-term care residents and improve their quality of care and quality of life. Finally, the Ombudsman Program believes that the funds being used for Delmarva's enhanced MDS duties would, in the short run, be better used in (1) increasing the number of HRA surveyors to ensure that plans of corrections submitted by nursing homes in response to deficiencies are implemented, (2) establishing the long-promised complaint investigation unit in HRA so that complaints of potential, actual, and imminent harm to residents are investigated in a timely manner and steps taken to ensure that the nursing home's policies, practices, and conditions are timely changed/corrected to prevent harm to additional residents; and (3) promoting and supporting "culture change" in the District's nursing homes.[28]

IV. OMBUDSMAN PROGRAM RECOMMENDATIONS

The quality of nursing home care in the District of Columbia continues to be a serious problem that will only worsen unless the Department of Health takes immediate action to fulfill the promises made in January 2002 and reiterated in May 2005. For DOH to successfully meet the stated goals of its four major initiatives, the Ombudsman Program recommends that the District government take following steps:

---

prevalence of pain were more likely to assess and treat residents' pain appropriately than nursing homes rated as having low prevalence of pain.

[28] Section IV, following, "Ombudsman Program Recommendation," explains the concept of "culture change" in the nursing home context.

A. Monitoring and Enforcement

DOH must expand and train its nursing home survey and complaint investigation staff to strictly enforce District and federal nursing home regulations, impose appropriate fines and sanctions for infractions, and ensure compliance with penalties imposed by monitoring the implementation of plans of correction and payment of all monetary penalties imposed. At the same time, as stated in its 2003 "Broken Promises," the Ombudsman Program strongly believes that the enforcement mechanism designed to compel compliance with the District's 2002 nursing home regulations must be something more than simply a schedule of fines. To be effective in improving the quality of nursing home care and services, **the remedy for a nursing home deficiency cannot simply be a civil monetary penalty.** Further, the Ombudsman Program has consistently recommended to the Department of Health that, at the very least, schedule of fines adopted to compel compliance with the District's 2002 nursing home regulations should classify violations of 22 DCMR 3200 *et seq.* as follows:

- a violation that causes actual physical or emotional/psychological harm to a resident be classified as a Class 1 infraction;
- a violation that poses an imminent danger to a resident's health, safety, or welfare or that abridges a resident's right to freedom from neglect, exploitation, or physical, mental, verbal, or sexual abuse be classified as a Class 2 infraction; and
- a violation that impacts a resident's health, safety, or welfare, but does not pose an imminent risk of harm, be classified as a Class 3 infraction.

The Ombudsman Program also strongly opposes an enforcement system that provides a civil monetary penalty alone as a remedy to poor care. Merely imposing a fine is not enough to ensure compliance, especially when the amounts of the fines are so low that paying them is much less costly than correcting the deficiency. A plan of correction, as well as a civil monetary penalty, should be required for infractions of the 2002 District nursing home rules. However, **when a plan of correction is required, it is critical that the facility be given a specific and reasonable date by which to correct the violation and that an inspector be assigned to reinspect, and be held accountable for reinspecting, on the date specified for correction.** If the deficiency is not corrected by the date specified, compound fining of the facility for a repeat offense should immediately commence. Thus, 16 DCMR 3201.2 should also be amended to provide that each day of violation following the day by which the violation is required to be

corrected should constitute a separate, repeat infraction and be fined as such. This change is important to ensure the imposition of strict, timely, and appropriate plans of correction on facilities.

In addition, the Ombudsman Program believes that, as in other jurisdictions, additional remedies be included in the enforcement scheme, such as the imposition of staffing ratios, hiring of specialists to train staff, placement of a receiver or new management team, and denial of new admissions. Similarly, as in other jurisdictions, the Ombudsman Program recommends that the fines collected for infractions be kept in a separate fund designated for hiring and training additional inspectors, hiring receivers/monitors for substandard facilities, making emergency repairs, and hiring additional staff to prevent imminent harm to residents when facilities fail to act -- the cost of which would then be subtracted from the Medicaid and Medicare payments to the facilities from the District. In Maryland, for example, the "Nursing Homes – Quality Assurance" bill, passed in 2000, not only increases fines for nursing home violations, but also provides as follows:

> . . . the amount of the penalty imposed, together with any accrued interest, shall be placed in a fund to be established by the Secretary and shall be applied exclusively for the protection of the health or property of residents of nursing homes that have been found to have deficiencies, including payment for the costs of relocation of residents to other homes, maintenance or operation of a nursing home pending corrections of deficiencies or closure, and reimbursement of residents for personal funds lost.

Similar language establishing a fund for fines paid by District nursing homes should be added to the regulations enforcing the District's 2002 nursing home rules.[29]

Finally, the Ombudsman Program recommends that the Department of Health create a long-term care task force to focus on chronically poor performers and make annual survey reports on these offenders available to the public.[30]

---

[29] A "Survey of State Use of Civil Monetary Penalties and State Fines," conducted by Charlene Harrington and Theo Tsoukalas, University of California at San Francisco, and Cynthia Rudder, Long Term Care Community Coalition, funded by he Commonwealth Fund, and presented at the annual meeting of the National Citizens' Coalition for Nursing Home Reform, in October 2005, found that **only six states, the District of Columbia being one of the six,** have no separate account for funds collected from federal and state fines for nursing home violations. Thirty-five states at the time of the survey had almost $56 million available in accounts from federal and state fines to fund such projects and activities as receiverships, relocations of residents from substandard homes, survey and inspection activities, Ombudsman Program activities, and special projects for nursing homes for quality improvement, including "culture change."

B. Resource Center

The D.C. Aging and Disability Resource Center must be fully funded in order to fulfill its mandated duties, including the monitoring of individual providers to insure that correct information about availability, costs, services, and quality of care is being disseminated to the general public. In addition, in order to provide District residents with the choice mandated under federal law to receive long-term care services in their homes and communities, rather than in an institution, the waiver programs must be fully funded and utilized by residents, subsidized housing and subsidies to make homes handicapped-accessible must be made available, and home care and personal care workers must be given the living wage that will keep them from going to Maryland and Virginia for work while District residents languish in institutions for lack of home care services.[31]

C. Casemix System

Since January 2002, the Department of Health has promoted the advantages of a casemix system of Medicaid reimbursement over its current payment system, and since January 2002, DOH has been promising to provide a casemix system. It is time for DOH to deliver what has been promised and to implement and maintain a workable and reliable casemix system that will hopefully both improve care and correct the District's problems of Medicaid overpayments to nursing homes.[32] At the same time, the amendments to the final rulemaking for the casemix system (29 DCMR 6500), especially those containing spending ceilings for resident care but not for capitol spending costs, raise the Ombudsman Program's concerns about the ability of the Department of Health to implement a workable system for both the nursing home industry and residents. The Ombudsman program, therefore, recommends that a "pilot program" be implemented to determine whether the proposed casemix system will correct current Medicaid reimbursement overpayments and improve quality of care.

---

[30] The Committee on Health Services, Chaired by David Catania, created a Long-Term Care Task Force that is reviewing this suggestion through its subcommittee.

[31] Similar recommendations were made by the D.C. Council's task force. *Cf.*, Susan Levine, "Panel Urges Changes in Elderly Care," *The Washington Post*, Dec. 1, 2005, pp. 3 & 9.

[32] *Cf.*, "Review of District of Columbia's Accounts Receivable System for Medicaid Provider Overpayments," prepared by the Office of Inspector General, Department of Health and Human Services, August 2005.

D. Training to Address Problems with Care

- As noted above, little progress has been made by the Department of Health on this initiative since it was first articulated in January 2002. Also, as noted above, the Ombudsman Program has serious concerns about the effectiveness of the one step that appears to have been taken by the Department of Health to improve the quality of care in District nursing homes, i.e., restructuring the Delmarva Foundation contract to focus on verification of MDS data. While supporting DOH's stated goal of assisting the nursing home industry to design and implement model training programs for providers and staff, the Ombudsman Program strongly recommends that other steps be taken, as follows, to improve care in the District's nursing homes.

1. Regulatory Changes: Restraints and Staffing

Restraints:

As noted earlier in this report,[33] the current District regulations regarding the use of physical and chemical restraints do not comply with Federal regulations and do not go far enough to eliminate the abuse of physical and chemical restraints. The District's nursing home licensure rules regarding the use of physical and chemical restraints must be amended to follow federal law in order to encourage individualized and restraint free care.

Staffing:

Studies for CMS conducted by experts in the field, as well as studies conducted by the National Citizens Coalition for Nursing Home Reform (NCCNHR) and by other research organizations, show a direct relationship between staffing and quality of care. The study done for CMS, using data from a representative sample of 10 states including over 5,000 facilities, identified nursing assistant and nursing/other licensed professional staffing levels below which facilities were more likely to have quality problems (Centers for Medicare and Medicaid Studies 2002). The minimum levels were 2.8 hours per resident per day for nursing assistants, and 1.3 hours per resident per day for LPNs and RNs.

Nevertheless, the report found that, in 2000: "Over 91% of nursing homes have nurse aide staffing levels that fall below the staffing thresholds identified as minimally necessary to provide the needed care processes for their specific resident population. In addition, over 40% of all nursing homes would need to increase nurse aide staffing by 50 percent or more to reach the

[33] *Cf.*, Note 18.

minimum threshold associated with their resident population, and over 10 percent would need to increase their nurse aide hours in excess of 100 percent...." (Centers for Medicare and Medicaid Studies 2002). More recently, the report on long-term care quality for the National Commission for Quality Long-Term Care, cited earlier, noted that Quality Initiative studies "have repeatedly pointed to the need for additional staffing and other resources in order to sustain quality process enhancements" and that the Institute of Medicine has concluded "that quality of life as a featured outcome will continue to be a fairly low priority in nursing homes until homes are sufficiently staffed to allow for more individualized focus."

While the District's 2002 nursing facility rules did provide for a phased-in increase in staffing,[34] the Ombudsman Program believes that NCCNHR's recommended staffing ratio of 4.13 hours of combined nurse and nursing assistance direct care per resident per day is needed to provide care that does more than prevent serious harm to residents. At the same time, the Ombudsman Program recognizes that staffing shortages in nursing homes have many causes, such as low wages, few or no benefits, lack of opportunity for advancement, physically and mentally stressful working conditions, and poor management and training. Increased wages and benefits, the introduction of career ladders, and improved training and supervision would clearly help to recruit and retain nursing home staff, especially nursing assistants.

2. Culture Change

The Ombudsman Program believes that, even if the Department of Health fully implemented its stated initiatives, any increase in the quality of care for residents will not be permanent and substantive unless administrators adopt and implement alternative programs

---

[34] *Cf.*, 22 DCMR 3211.3 Beginning no later than January 1, 2005, each facility shall employ sufficient nursing staff to provide a minimum daily average of 3.5 nursing hours per resident per day. Nursing staff shall be provided in accordance with the following minimum staff-to-resident ratios:

(a) Licensed nurses (RN or LPN) providing planning, coordination, and supervision at the unit level:
Day Shift - 1 FTE for each 35 residents (0.23 hours per resident day)
Evening Shift - 1 FTE for each 45 residents (0.18 hours per resident day)
Night Shift - 1 FTE for each 50 residents (0.16 hours per resident day)
(b) Direct care staff (RN, LPN, or CNA) providing treatment, medications, and other patient care:
Day Shift - 1 FTE for each 5 residents (1.6 hours per resident day)
Evening Shift - 1 FTE for each 10 residents (0.8 hours per resident day)
Night Shift - 1 FTE for each 15 residents (0.53 hours per resident day)

which foster a "culture of change" within each and every nursing facility.[35] The ultimate goal of these alternative programs is to move away from the medical model of nursing home care that has dominated the operations and management of nursing homes in the U.S. and to focus instead on the individual physical, social, psychological, and spiritual needs of each resident and on involving the front-line staff in the decision-making process in order to positively affect the daily operation of a home.

The Ombudsman Program is not alone in recommending that the Department of Health provide funding and support to implement "culture change" in the District's nursing homes. The "Report on Long-Term Care Quality" for the National Commission for Quality Long-Term Care, cited earlier, asserted that these alternative programs "provide tantalizing glimpses of how nursing home culture, operations, and outcomes may be reoriented and seem to imply that some improvement in resident and staff satisfaction can be obtained without increasing costs or sacrificing avoidance of negative outcomes." The report went on to offer as one of its three major recommendations for improving long-term care quality that a National Demonstration of Nursing Home Culture Change Models be promoted and implemented. In addition, an article on Quality Improvement Organizations, in the August 2004 edition of *Better Jobs Better Care,* by Elise Nakhnikian, Communications Specialist for the Paraprofessional Healthcare Institute, noted that "some within CMS have begun to believe that long-lasting improvements can only come from a wholesale transformation of the nursing culture."[36] The article goes on to quote Marguerite McLaughlin, project coordinator for Quality Partners' Nursing Home Quality Improvement Initiative, [37] as follows:

> CMS felt that we'd see a greater success story for each nursing home by improving clinical systems. I think what we're finding is that if our focus is clinical and all data, we're not really affecting people. So we proposed that we hook people up with culture change initiatives, getting nursing homes to introduce a more resident-centered model. (p.5)

---

[35] The Methodist Home is the only nursing home in the District to institute an alternative long-term care program. The program, Wellspring, is discussed below in example (c).

[36] Page 5.

[37] CMS awarded a contract to Quality Partners of Rhode Island to provide technical assistance to Quality Improvement Organizations (QUOs) across the country on the Nursing Home Quality Improvement Initiative because "Most QIOs had little involvement with nursing homes prior to the current scope of work and few had staff with experience in long-term care" (p. 3). DelMarva Foundation is the QIO for the District of Columbia.

The Ombudsman Program recommends that the Department of Health dedicate funds to research, support, and implement the following alternative programs in the District.

(a) The Eden Alternative:

An alternative nursing home approach, Eden uses plants, animals, and children to create an enjoyable and stimulating nursing home environment for residents and staff. This approach focuses caregivers and the culture of the nursing facility on *what is best for the resident.* Another important aspect of the Eden approach is the empowerment of staff by giving them the responsibility and ability to make decisions about matters such as their own work schedules. Research conducted in "Edenized" facilities by Southwest Texas State University has shown a 50% reduction in the incidence of decubitus ulcers; a 60% decrease in difficult behavioral incidents among residents; a 48% decline in staff absenteeism; and an 11% drop in employee accidents.[38]

(b)The Pioneer Alternative:

The Pioneer approach aims to achieve a change in nursing facility culture by creating a community in which each person matters and makes a difference. The Pioneer Network focuses its efforts on taking a more holistic, individualized approach to nursing home care by working to change governmental policies and regulations that work against providing residents with a maximum of autonomy and independence; change individual and societal attitudes toward aging and elders; change elders' attitudes towards themselves and their aging; and change the attitudes and behavior of caregivers toward those for whom they care. The Pioneer Network refers to this work as a "culture change." Their aim is nothing less than transforming the culture of aging in America, and in nursing homes.[39]

(c) The Wellspring Alternative:

The Wellspring model is based on the idea that the best decisions about care are made by the staff who are best acquainted with the residents. This approach combines six key elements to improve nursing home quality: developing management committed to making quality of resident

---

[38] Paul R. Willging, American Society on Aging, *The Eden Alternative to Nursing Home Care: More than Just Birds, available at* http://www.asaging.org/at/at-214/eden.html.
[39] http://www.pioneernetwork.net/index.cfm/fuseaction/content.display/page/ValuesVisionMission.cfm

care the first priority; providing training materials and educational courses for staff at the facility; creating "care resource teams" that receive training in a specific area and then teach the other staff; empowering all staff to make decisions affecting the quality of care and the working environment, such as staff schedules; and continually reviewing the facility's progress in meeting these goals. Good Shepard Services in Wisconsin, one of the eleven homes that implemented the Wellspring approach was able to reduce their nursing staff turnover rate from 105% to 23% over five years.[40]

(d)Growing Strong Roots: Peer Mentoring Program:

As demonstrated by the Growing Strong Roots: Peer Mentoring Program,[41] if the front-line staff is trained and valued for the important role they play in the long-term care facility, then the quality of care for residents can increase. Developed by the Foundation for Long-Term Care (FLTC), this program combines peer mentoring for Certified Nursing Assistants (CNAs) and trainings for nursing home management with a focus on helping CNAs becomes an integrated part of the facility, thus increasing satisfaction and retention of CNAs and improving the care provided to residents. *Growing Strong Roots* emphasizes the critical role of the nurse's aid to the functioning of the nursing facility and values the experienced employee as he or she mentors the newcomer. This plan, evaluated in eleven nursing homes, result in CNA retention rates increasing by 25%. Through this project, a nursing home can initiate and maintain improvements in their daily operations by creating a "culture of care" within the facility.

IV. CONCLUSION

The federal and District nursing home laws set minimum quality of care standards for the nursing home industry. It appears, however, that some D.C. nursing homes fail to meet even these minimum standards while others deliver only the minimum care and services to nursing home residents – care and services directed simply to avoiding serious mistakes that would cause actual harm to residents but that ignore questions about the quality or care and quality of life that residents are experiencing. When nursing homes fail to meet federal and local standards and

---

[40] Robyn I. Stone, Commonwealth, *Evaluation of the Wellspring Model for Improving Nursing Home Quality,* August 2002

[41] Carol R. Hegeman, M.S., Peer Mentoring of Nursing Homes CNA's : A way to Create a Culture of Caring,(2003).

blatantly violate the law, it is the duty of the surveyors and inspectors to enforce the law and ensure that violations are resolved and not repeated. The Ombudsman Program finds that this is one area where the District of Columbia fails the resident, by not doing enough to protect residents' rights, impose appropriate monetary penalties, and monitor and enforce plans of correction.

After evaluating approximately four and half years worth of survey reports, complaint data, DOH Quality Initiatives Plans, and studies by government and independent research organizations, the Ombudsman Program continues to have significant concerns about the health, safety, and welfare of the District's nursing home residents. The Ombudsman Program hopes, therefore, that this serves not only as a reflection of the current progress made by the DC Department of Health in improving the quality of care in the District's nursing homes, but also as a managerial tool for both the nursing home industry and D.C. Government officials willing to work on improving the quality of care and life for nursing home residents.[42]

V. CONTACT INFORMATION

To contact the D.C. Long-Term Care Ombudsman Program, please call Mary Ann Parker, D.C. Long-Term Care Ombudsman Attorney, 202-434-2116; or Jerry Kasunic, D.C. Long-Term Care Ombudsman, 202-434-2140; or write to The D.C. Long-Term Care Ombudsman Program, 601 E Street, N.W., Building A, Fourth Floor, Washington, D.C. 20049.

VI. ACKNOWLEDGEMENTS

The Ombudsman Program wishes to thank the following persons for their assistance with this report:

Mary Alice Kane, MD and Board Certified Internist. First Year Law Student at George Washington University, for research and review of surveys of District nursing homes while an intern with the Legal Counsel for the Elderly, D.C. Long-Term Care Ombudsman Program.

Alejendra Pinkerton Perez, First Year Law Student at George Washington University, for research and review of surveys of District nursing homes while an intern with the Legal Counsel for the Elderly, D.C. Long-Term Care Ombudsman Program.

---

[42] This report concludes the Ombudsman Program's "Broken Promises" project.

Zita Dresner, former attorney for the D.C. Long-Term Care Ombudsman Program, for research, editing, and writing assistance.

Robins, Kaplan, Miller, and Cireesi, Law Firm for sponsoring and supporting the Ombudsman Program during the completion and distribution of the report.

The D.C. Long-Term Care Ombudsman also wishes to thank the D.C. Department of Health, Health Regulations Administration and the Medical Assistance Administration for sharing information during the research period of this report.

IMPROVING NURSING HOME ENFORCEMENT: FINDINGS FROM ENFORCEMENT CASE STUDIES

Contract Number:
500-00-0026 0003

March 22, 2007

Prepared by:
Helena Louwe, RN
Carla Parry, PhD, MSW
Andrew Kramer, MD
Division of Health Care Policy
and Research
University of Colorado Health
Sciences Center

Marvin Feuerberg, PhD
Project Officer
Centers for Medicare &
Medicaid Services

Data Collectors:
Teresa Aycock, RN
Maureen Hirsch, RN, MN, CS
Elizabeth McHenry, MA, MPA, RN, LNHA
Audrey Stob, RN
Annette Sweet, RN, MBA, BSN
JaneEllen Walker, RN
Cecelia Bost, RN, BSN

Consultant:
Kay Wagner, RN, MS

This study was developed under a Centers for Medicare & Medicaid Services contract, number 500-00-0026 0003, to the Division of Health Care Policy and Research, University of Colorado Health Sciences Center. The content of this report does not necessarily reflect the views or policies of the Centers for Medicare & Medicaid Services

TABLE OF CONTENTS

1. BACKGROUND

Poor quality of care is a major concern in U.S. nursing homes. Extreme vulnerability of nursing home residents, low skill levels of staff, limited participation by physicians and other skilled medical professionals, and the large number of homes have all contributed to this problem. Various approaches can improve or assure the quality of nursing home care including internal quality improvement of practices by the nursing home industry, public reporting of consumer information of nursing home quality, federal regulatory oversight, and/or the institution of minimum staffing ratios. Since a majority (78%) of nursing home residents are reimbursed through the government funded Medicare and Medicaid programs and virtually all nursing homes are Medicare or Medicaid certified, federal regulation has a key role in assuring the quality of nursing home.[1]

Assuring that high quality care is provided by the nursing home industry is a formidable task. Commissioned by Congress, the Institute of Medicine (IOM) reported widespread quality of care problems in nursing homes in 1986 and outlined extensive reforms in the nursing home regulatory process.[2] Since the IOM report, strategies to improve the quality of nursing home care have largely taken the form of federal regulation and enforcement, including the institution of the Nursing Home Regulatory Act (NHRA).

State survey agencies (SA) are contracted by the federal government to survey nursing facilities annually to assure compliance with the federal guidelines for nursing home care. Non-compliance with a federal guideline for nursing homes results in a citation, which is assigned a level of severity and scope. For CMS to enforce standards, States are required to refer certain types of noncompliance (e.g., immediate jeopardy cases) to CMS for a potential sanction, such as a Civil Money Penalty or the Denial of Payment for New Admissions.

Based on the Nursing Home Reform Act (NHRA), the Centers for Medicare & Medicaid (CMS, formerly HCFA the Health Care Financing Administration) revised the annual nursing home survey and certification process to assess compliance with regulations.

Research has found significant problems with the survey and certification process including inadequate identification of quality of care concerns by the surveyors, reliability and validity concerns with the outcome measures of the state survey, and inconsistency in the implementation and administration of the survey and enforcement process.[3-5] In a HCFA-funded study conducted by the University of Colorado Health Sciences Center (UCHSC) under contract to Abt Associates, the sensitivity of survey activities to detect quality of care problems was found to be less than 50% for various quality measures.[3] This finding was supported in a report to Congress prepared by the Health Care Financing Administration, with Abt Associates and UCHSC, and echoed in a report of the General Accounting Office in the same year: 1998. The GAO concluded that the federal enforcement process cannot be effective in its mandate to correct quality of care problems if the process for identification of these problems is deficient.[4]

More recent oversight investigations by the Office of the Inspector General (OIG) have found that 8 percent of required nursing home enforcement cases were not referred to CMS.[6] Another OIG investigation[7] found that of 55 cases they examined requiring termination, CMS did not apply the mandatory remedy as required in 30 cases (55 percent). A comprehensive investigation by the US Government Accountability Office (GAO) found that despite increased oversight by CMS, " . . .inconsistency among state surveyors in conducting surveys and understatement by state surveyors of serious deficiencies."[8]

In response to concerns about the consistency of the process used in state surveys, HCFA funded the UCHSC to adapt and pilot its research instrument to meet the requirements of the state survey.[9] Subsequently, this approach was refined and tested in several states and sites, and is now being tested in a five-state demonstration.[10;11] Some of these same quality assessment methodologies are used in the study reported herein. The results of these initial tests were promising, with state surveyors more frequently and consistently identifying resident outcome problems than in the standard survey.

Finally, research indicates that the type of deficiencies issued to nursing facilities varies greatly by state, suggesting inconsistency in the survey process and the process of issuing deficiencies.[5;12] In addition, Harrington & Carrillo[12] found a 100% increase in the number of facilities with no deficiencies for the period between 1991-1997 and a 44% decrease in the average number of citations. While some have argued that trends for this period may reflect an actual improvement in quality of care in nursing homes, GAO findings suggested this was not the case.[4]

More recent data indicates that high variability for the nation over time and between states has continued into the present: "From 2001 to 2005, the percentage of surveys resulting in a citation for deficiencies at the actual harm level or higher decreased from 21.9 percent to 16.5 percent. Similarly, the percentage of surveys resulting in the determination of substandard quality of care declined from 4.5 percent in 2001 to 3.3 percent in 2005."[13] In 2004, the percentage of nursing home surveys resulting in zero health deficiency citations ranged between about 1 percent for West Virginia and North Dakota to over 25% percent for New Hampshire and Oregon (Nursing Home Data Compendium, Table 4.6).[13]

Evidence of meaningful improvement in the quality of care since inception of the NHRA is lacking. The survey and enforcement process has demonstrated modest decreases in inappropriate use of physical restraint, psychotropic drug use, and hospitalization, but the overall quality of care in nursing homes remains a matter of concern as evidenced by the large percentage of serious deficiencies and/or repeat deficiencies incurred by nursing homes.[4;14;15] In particular, the high rate of repeat deficiencies (40 %) brings the effectiveness of the regulatory process into question.[16]

1.1. The Effectiveness of Enforcement

Basically, the enforcement system relies on the deterrent effect of enforcement to correct identified problems in nursing homes that receive a deficiency, and to prevent their reoccurrence in these homes and others who might not provide adequate care in the absence of this enforcement system. Although many aspects of this system have been studied, there is little empirical evidence supporting the most fundamental assumptions.

Put simply, we do not know the impact of enforcement on the quality of care. Up until recently it has not been possible to measure enforcement – the data have been widely scattered and there has not been any centralized database. Absent such a database, researchers have used deficiencies as a proxy for enforcement. But the receipt of a deficiency is only the beginning of an enforcement process, a process that may, but usually does not, result in the imposition of a significant sanction. Fortunately, a centralized database has become available that permits the generation of enforcement measures and for the first time, an analysis of the impact of enforcement on resident outcomes. This ongoing study complements the qualitative case studies reported here.

The above noted widespread variation in deficiency citation rates both between and within states and over time has been viewed by the industry as evidence of inconsistency and erroneous citations where the rates are high; it is assumed that nursing homes are generally providing good care in compliance with federal regulations. In contrast, nursing home advocates think that the general level of care is poor and that the low citation rates are evidence of an ineffective enforcement system and failure to enforce federal regulatory standards. There has been no **independent** assessment of whether citations are appropriate and consistent with federal regulations. This study will address that fundamental question and is unique in at least two aspects:

- There have been no studies that have examined the *process* of enforcement – an objective that inherently requires a longitudinal (and qualitative) design. As we will show below the process of enforcement begins with the identification of noncompliance by nursing home surveyors, the issuance of a deficiency, a Plan of Correction (POC) in response by the provider, revisit by the survey agency to determine if the POC has been implemented, potential appeals by the provider, and possibly the issuance of a sanction. This process takes place over time with meetings and discussions in the nursing home and survey agency. Essentially, this process is the black box of enforcement, a process that is difficult to observe. Reports by the GAO and OIG have often looked at one or another aspect of this process – e.g., whether high-level deficiencies are appropriately referred to the CMS' Regional Office for enforcement sanctions – but they have not looked at the entire process. This observational study constitutes a first time investigation look into the black box.

- This study will also employ investigatory protocols to independently determine for the study cases if the citations are inappropriately generated for nonexistent problems, as the industry often claims, or inappropriately not cited for regulatory violations, as often asserted by the nursing home advocates.

2. METHODS

While qualitative methods are often assigned a secondary or nominal role in health care and policy research, this need not be the case. As David Morgan notes,[17] qualitative methods are uniquely suited to exploratory and confirmatory work, and to inquiries that seek to answer how and why certain outcomes are produced. In the case of this study, process and outcome variables are somewhat confounded in the survey and enforcement process, making any inquiry complex. A qualitative approach is uniquely suited to this dilemma because of the ability to 'unpack' the relationship between process and outcome. It is also ideally suited to the assigned task because qualitative (naturalistic) inquiry is able to capture the meaning that informants assign to their decisions and actions in the survey and enforcement process, a domain that is absent in quantitative approaches and would be difficult to capture via quantitative means alone. Thus, a qualitative approach was employed in this study because of its strengths: the ability to address and uncover decision-making processes; explain patterns of reporting and enforcement (some of which had already been demonstrated quantitatively); and answer questions emerging from prior research and observation that could not be addressed effectively through quantitative means alone.

It should be noted that case studies, as a methodology, are inherently labor-intensive and the 26 reported here represent both theoretical saturation (the standard in qualitative methods that is comparable to the concept of "power") and a relatively high number of cases. The results of the 26 case studies were remarkably consistent, even given the geographic diversity of the sample, and it is unlikely that a larger sample size would have yielded different results. With respect to the standard of rigor in qualitative research, it is important to recognize that the data collection protocol for this study required a very high level of skill and intensive training for the nurse data collectors to conduct. This presented a significant problem in data collector recruitment and indeed, one data collector was dismissed after data collection had begun because she was unable to fully grasp and enact what was required.

It should also be noted that the states and facilities volunteered their participation in this study. Although we make no claim that the sample is representative of the U.S., any bias that may have resulted from the volunteer sampling strategy is likely in the direction of producing results that are more favorable to the survey agencies and nursing homes. Apart from the 10 states that declined participation, two states withdrew after initially consenting, and six case studies were aborted. Among those that did participate, this independent study found many problems that were not identified by the survey agency, as well as instances of nursing home responses that did not effectively address identified deficiencies. Given the voluntary nature of

the sampling, it is unlikely that a more flattering portrait of the enforcement process would have emerged had more case studies been completed.

2.1. Overview of Data Collection and Analysis

The qualitative case studies followed the nursing home enforcement process longitudinally from the beginning of the annual re-certification survey until completion of the nursing home re-certification surveys. Case studies were conducted in 25 nursing facilities in four different states, with the results reported as 26 case studies.[1]

The study evaluated the survey's ability to identify deficient practices and the impact of enforcement activities on nursing home care. This evaluation occurred via observation of facility care practices during a series of visits; for each case study, three visits were made to the targeted nursing home facility and three visits/observations were made of the state agency/survey team. The purpose and content of these visits is described in detail in section 2.6.

Data collection consisted of direct observation, in-depth interviews, and detailed record review. Instruments and questionnaires were designed to encourage a systematic and comprehensive approach to data collection, while allowing flexibility and responsiveness to accommodate varying circumstances and emergent findings. Field notes were taken in real time, then notes were transcribed and prepared for electronic transmission to the study coordinator. An initial review of the data occurred in the field where RN data collectors used their professional expertise to interpret the data and provide summary evaluations. For each stage of the case study, data collectors completed a research summary sheet, by transposing their field notes in detail and composing a summary evaluation tailored to the research questions and study objectives. These summary evaluations and field notes were then reviewed by the study coordinator and prepared for further analysis.

Using the summary evaluations and field notes created by the nurse researchers, data were analyzed using a combination of inductive and deductive approaches. Data were coded deductively, using the study goals, steps of the enforcement process, and key terms (i.e. severity, impact, etc.) as markers for data abstraction. Data were simultaneously abstracted and coded inductively, using emergent themes identified by the data collectors and study coordinator. This method of axial and thematic coding was followed by a synthesis and summary of the observations *by case study* and *across case studies*. Case studies were reviewed, compared, and contrasted to discover trends and to assess the accuracy of analytic conclusions. Comparisons were made between states, facilities, the survey team, and the study team regarding quality of care. Explicit attention was given to negative cases in order to better understand the potential mechanisms driving differing results. This method was particularly useful with respect to exploration of issues such as differences in monetary penalties between states or the downgrading of citations.

[1] In one survey, two case studies were conducted: one on a standard survey and one on a complaint.

2.2. RN Data Collectors

Registered nurses (RNs) were recruited to conduct on-site data collection; one for each of the four participating states. The study team placed great emphasis on recruiting nurses familiar with the nursing home survey, and who had substantial professional experience in a nursing home setting. In addition, since case studies relied heavily on observation and interviews, it was imperative that the nurses be able to skillfully employ these data collection techniques. When the desired combination of traits proved unattainable, we sought nurses with professional experience in the nursing home setting who had interpersonal skills amenable to qualitative research. Specifically, we sought evidence of the ability to establish easy rapport with people, good observation skills, and the ability to persistently elicit information from informants without alienating them. All data collectors were RNs recruited in the study state of their residence, all had extensive professional experience in nursing home care, each had experience with the nursing home enforcement process either in a consulting capacity to the nursing home industry or in a managerial position in a nursing facility.

Each data collector received one week of training at the University of Colorado Health Sciences Center Facilities, in Denver. The training consisted of instruction in the study protocols and an introduction to qualitative research techniques, including: classroom instruction, role-play, and experiential application of the observation and interview techniques at a local health care facility. Immediately following the training, a member of the research team accompanied each data collector to a study facility in her state to practice the new skills the data collection protocols on-site.

2.3. State, Facility and Care Area Selection Process

The study protocol for selection of states, facilities, and care areas is described in this section of the report and is illustrated in Figure 1.

2.3.1. State Selection Process

Four states were recruited from the ten federal enforcement regions. Regional representation was ensured by inclusion of states from four of the CMS geographic regions: west, mid-west, mid-Atlantic and south. A purposive sample was chosen based on state enforcement and citation records provided by CMS. State selection relied upon two criteria that favored states with higher citation rates in targeted care areas and sought to create a sample that reflected variation in enforcement procedures. States exhibiting deficiency rates above the national average were selected for inclusion in the study because adequate deficiency activity was necessary to assure the team would encounter surveys in which citations were given. Once this initial deficiency criterion was met, states were selected on the basis of variation in enforcement procedures to assure that the study included a range of programmatic approaches. A CMS introductory note was emailed to each selected SA office, followed by a faxed letter explaining

the study. In addition, every effort was made to contact each SA by telephone. Ultimately the selection of states was also influenced by the willingness of the states to participate in the study. Ten states declined participation, claiming lack of resources and manpower. Two states withdrew after initially consenting, and in one state no qualified data collector could be recruited.

Figure 1: State, Facility, and Care Area Selection Process

Error! No topic specified.

* If more than 1 targeted care area was identified, the study care area was selected based on prevalence (lower prevalence areas were chosen first to provide an adequate sample in all of the targeted care areas) and scope/severity (preference for higher scope/severity).

2.3.2. Facility Selection

Within the four participating states, the study sample was selected from all nursing facilities receiving a Medicare/Medicaid standard survey for re-certification during the time of the field data collection. Facilities undergoing extended partial surveys or abbreviated standard surveys were not eligible, due to significant differences in the scope of the survey tasks performed in these types of evaluations.

Facilities were selected when the annual re-certification survey revealed preliminary findings that indicated a potential citation for one of the targeted F tags in the first two days of the survey. The study team also selected facilities purposively in order to achieve a relatively representative distribution of those F tags that were targeted in the study. Overall, selected nursing facilities evidenced a high level of willingness to participate.

Case studies were initiated in thirty-one nursing facilities during the annual re-certification survey. Six case studies were aborted, for two reasons: 1) refusal of the participants (refusal of the state or the facility staff); or, 2) failure to issue a citation in one of the study's targeted care areas (despite preliminary survey findings indicating a potential citation). Thus, with the removal of the 6 aborted cases, case studies were completed in 25 facilities.

One facility was subjected to a complaint investigation during the compliance cycle, which was followed as a separate case study. With the addition of this case, the 25 facilities yielded 26 completed case studies.

Table 1: Number & Distribution of Facilities and Case Studies

State	# Facilities with Completed Case Studies	# Completed Case Studies
1	7	7

2	4	4
3	8	8
4	6	7*
Total	25	26

*Includes complaint investigation.

2.3.3. Study Care Area and F Tag Selection

To investigate the impact of the enforcement process on the quality of care in nursing facilities, the study team identified five care areas of interest: pressure ulcers, weight loss, abuse/neglect, physical restraints and pain management. Study care areas were linked to federal regulatory tags, or F tags, outlining standard practice guidelines (Table 2).

To study survey accuracy and the impact of enforcement on nursing staff behavior, each case study was required to have at least one F tag for which the preliminary survey findings showed facility practices sufficiently deficient to result in a citation. Additionally, to evaluate the surveyors' ability to detect problems, an additional study care area was selected at each site. The requirement for this second care area was that the preliminary survey findings indicated no deficient facility practices.

Table 2: Study Care Area Related to F Tag

Care Area	Definition	F Tag	Regulation
Pressure Ulcer	At risk for pressure ulcers Current pressure ulcer stage 2, 3, 4	F314	Prevention and /or treatment of pressure ulcers
Weight Loss	At risk for weight loss 5% weight loss in last 30 days 10% weight loss in last 180 days	F325	Nutritional status
Abuse/Neglect	At risk for abuse/neglect Incident of abuse/neglect in past year	F223 F224 F225	Free from abuse Staff treatment of residents Investigation/reporting of abuse
Physical Restraint	Current use of devices restricting free movement	F221 F324	Physical restraints Prevention of accidents
Pain Management	Routine pain medication and daily pain	F309	Care and services

In each case study, the study team selected at least two study care areas: one for which the survey team had indicated a potential citation (F tag) and one for which no such indication existed (alternate F tag). F tag selection was determined by the survey team's findings. The study team aimed to achieve equal distribution of F tags for the overall study; this objective, however, was dependent on duration of data collection and availability of F tags. The selection of the second (alternate) F tag was based on each facility's deficiency history; care areas were targeted for which the facility had incurred one or more citations in the past 3 compliance cycles. If no such citation existed the data collector determined on-site which care area was the most suitable, because the surveyors had indicated that: 1) no problems were found; 2) facility records revealed a high prevalence/incidence rate for specific conditions; or 3) study observation indicated concerns for one particular care area. The selection of study care areas was limited to two per case study in order to allow the data collectors adequate time for thorough investigation while minimizing undue burden on the investigated nursing facility and SA.

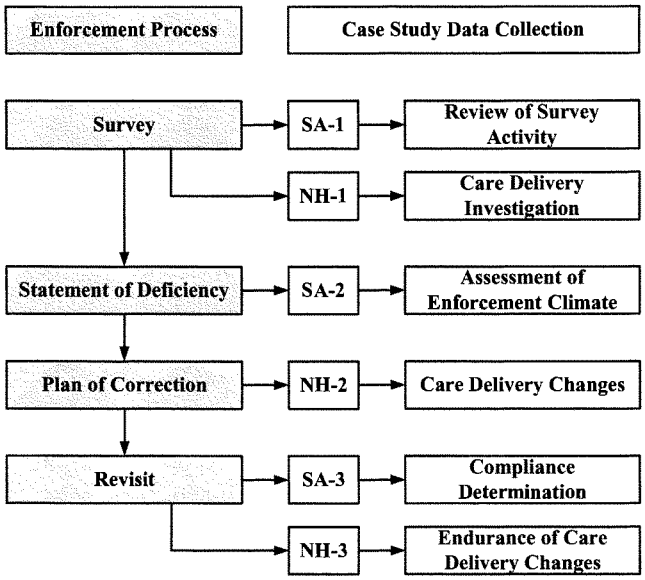
In each facility, the data collectors targeted 2-4 residents for an in-depth investigation. Residents were selected because their records indicated at-risk status for a condition relevant to one or both of the selected study care areas.

2.4. Data Collection

Each SA committed to share the preliminary survey findings with staff at the Division of Health Care Policy and Research (DHCPR) by the second or third day of the agency's survey visit. DHCPR staff determined whether the facility met the eligibility criteria for a case study. If the agency's preliminary findings demonstrated significant concerns in one or more study care areas, the nursing facility was chosen for inclusion in the study project. Deficiency history and facility observations determined the alternate study care area.

Once a facility was chosen, a total of six visits were conducted per case study to either the SA or the nursing home. These visits alternated between the SA and nursing facility for the duration of one enforcement cycle (from initial re-certification survey to re-certification). Visits coincided with distinct steps in the enforcement cycle: a) the survey; b) release of the Statement of Deficiency; c) last implementation date of the corrective actions outlined in the Plan of Correction; d) revisit; and, e) one month following implementation of the corrective actions. The study site visit protocol is depicted in Figure 2.

FIGURE 2: Overview of Data Collection Process



Each visit had a specific objective:

SA1 Visit: Visit to the nursing facility during the last day of the survey. The purpose of the SA1 visit was to observe the surveyors' decision-making process. Specifically, the study evaluated the survey team's ability to identify deficient practices through an independent observation of facility care practices. Observation of surveyors' investigative actions, F tag designation meeting, and exit conference with the facility. Data collectors were always present on the last day of the survey from the team's arrival until the team's departure from the facility following the exit conference. Data collection during this visit consisted of direct observation; questions were kept to a minimum and then only for clarification purposes. Even though the visit focused on decision-making and the F tag designation meeting, the data collectors also observed some of the investigative actions of the team and the interactions between facility- and state agency staff.

NH1 Visit: a 2-3 day visit at the nursing facility immediately following SA1 to independently study the facility's care practices. The focus was on the study care area relevant to survey citation and one alternate study care area not implicated in a survey citation. Data collection involved record review, observation of facility practices, and review of organizational

structures. The NH1 visit provided a baseline assessment to evaluate any changes resulting from enforcement process. During the NH1 visit, care delivery was observed for at least four sampled residents, who were either at risk or treated for a specified condition relevant to one specific nursing care area for which the survey had found no preliminary findings. The resident-centered assessment involved structured resident record reviews; facility record reviews; observation of specific care practices; and interviews with direct care and management staff. Structured assessments were conducted using protocols and tools derived from the Quality Indicator Survey (QIS).[18] The data collectors then determined for each resident review whether deficient practices had occurred and if so, whether the deficiency warranted a citation.

SA2 Visit: Visit to the SA following release of the Statement of Deficiency (SOD). The focus was on exploration of SA decisions and perceptions with respect to citations and designation of scope and severity through semi-structured interviews with surveyors, licensing/enforcement officers and supervisory staff.

NH2 Visit: 1-2 day visit at nursing facility to verify implementation of corrective actions. The focus was on care delivery modification involving residents implicated in the original F tag and, additionally all residents selected for review at NH1. Data collection consisted of record review; observation of care delivery, interviews with management, QA staff, and direct care staff.

SA3 Visit: Visit to SA following surveyors' re-assessment of facility compliance. The focus was on exploration of determination of compliance and SA staff perceptions of enforcement process effectiveness through interviews with re-visit officer(s) and supervisory staff.

NH3 Visit: 1-day visit to nursing facility one month following NH2. Focus on endurance of compliance. Focus on staff retention of knowledge related to in-services involving survey citations, continuation of corrected care practices according to regulation. Data collection consisted of record review, observation of care delivery practices and interviews with management staff and new hires.

In summary, the following qualitative methods were used to examine the accuracy and efficacy of the enforcement process, including: 1) direct observation of care practices relative to the investigated care areas; 2) interviews with nursing home direct care staff, management staff and residents regarding care delivery, management and organizational practices; 3) interviews with SA staff regarding their perceptions of care delivery in specific nursing facilities; 4) review of facility protocols and guidelines pertaining to the care areas under investigation; and, 5) review of selected individual resident records

Data collection tools were designed to encourage a systematic approach to the study subject while providing the nurse researcher maximum flexibility in order to allow on-going responsiveness to specific situations observed in the visited nursing facilities.

The nurse researcher recorded the data on provided data collection instruments at the time of observation and interview. The nurse researcher synthesized some of the information while in the field. Further analysis and selection of material for case studies was performed by DHCPR staff.

3. CASE STUDY FINDINGS

The federal regulatory system for nursing homes is complex, consisting of various components that depend on and/or support each other. The case studies conducted an in-depth study of this system by observing several distinct steps in the process, which are used to organize the findings. This chapter follows the enforcement process sequentially, as if following one nursing facility's experience through one enforcement cycle. The sections include: 3.1 Survey to detect and identify deficient practices; 3.2 Statement of Deficiencies, reflecting the formal survey outcome; 3.3 Enforcement, to encourage the correction of deficient practices; and, 3.4 Revisit, to evaluate adequacy and implementation of facility corrections. Each of these four sections is divided into three subsections. In the first subsection, a brief summary of the guidelines for that aspect of the survey is provided. In the second subsection, summary statistics across all case studies are provided. In the final subsection, the qualitative case study findings are highlighted on survey and enforcement practices.

3.1 Survey to Detect and Identify Deficient Practices

3.1.1. CMS' Annual Re-certification Survey

All facilities participating in the Medicare/Medicaid programs are subjected to regular surveys to determine compliance with the federal regulations. The survey initiates the enforcement process through detection and identification of deficient practices; those practices that do not meet the federal standards as outlined in the regulation. Surveys are conducted at least annually to re-certify a nursing facility into the Medicare/Medicaid programs. A survey determines a facility's compliance status either as compliant or non-compliant for each of the federal regulatory requirements or F tags. Non-compliance is established when a facility does not meet federal requirements for a specific F tag and results in a citation. If, during the survey, no deficient practices are identified, the facility is considered in compliance with the federal regulations and no enforcement is needed. In 2004, the percentage of surveys that were deficiency-free was 10.2%.

3.1.2. Survey Findings: Detection and Omissions

The case study surveys detected many deficient practices and many resulted in citations. These are discussed in the section on citation decisions. In this section the focus is on deficient practices that the survey did not detect, and hence did not cite; and, alternatively on those deficient practices that were identified by the surveyors but did not result in a citation during the survey.

3.1.2.1. Detection Problem

Twenty-five case studies *(complaint investigation excluded)* were evaluated for identification of deficient practices. The study detected deficient practices in 24 facilities; in 18 of these the survey found no deficiency related to the relevant F tag (Table 3). The deficiencies identified by the study involved many F tags including: dehydration (F227); weight loss (F225); inappropriate restraint use (F221); inadequate supervision and or monitoring to prevent accidents (F323); abuse and neglect (F223); inadequate pain management ((F309); and inadequate prevention or treatment of pressure ulcers (F314). Additionally the study often cited inadequate nursing assessment (F272) and/or care planning (F279).

For the six facilities where both the study and survey found deficient facility practices resulting in a citation, in some cases the study selected different but related F tags than the survey. Nonetheless, both the study and the survey determined that facility deficiencies had occurred. This highlights the issue that often different F tags are justifiable for the same care problem. In only one case study did the study not find deficient practice that warranted a citation and as such agreed with the survey that no deficiencies relative to the study area had been observed.

The study citations also assessed the Scope/Severity level and in most cases these ranged between D and G, with emphasis on the higher Scope/Severity levels E, F and G.

Table 3: Identification of Deficient Practices for Selected F tags Based on Survey and Study

	SURVEY		
	Deficient Practice Detected	No Deficient Practice Detected	Total
Study Evaluation			
Deficient Practice Detected	6	18	24
No Deficient Practice Detected	0	1	1
Total	6	19	25

3.1.2.2. Omitted Citations

At times the surveyors detected deficient facility practices, but these deficient practices did not result in a citation. These omissions occurred either through a deliberate process of decision-making on the part of the surveyors or the identified deficient practices never reached the decision-making stages. Omitted citations were in general not officially registered; hence, they disappeared from the federal enforcement process and escaped enforcement actions and regulatory scrutiny.

Omitted citations were a common occurrence for the twenty-three case studies for which the study had adequate data; all but one survey revealed at least one such omission. In addition, the omitted citations occurred with relative frequency, ranging from 1-5 F tags per survey. The omitted citations can be categorized as follows: 1) *missed,* for those that were identified as deficient practices, but never reached the F tag stage; 2) *comments,* for those identified deficient practices that were relayed to facility staff, but not cited; and, 3) *state citations,* for those deficient practices that were said to be issued as a state citation, and never occurred under a federal regulatory tag.

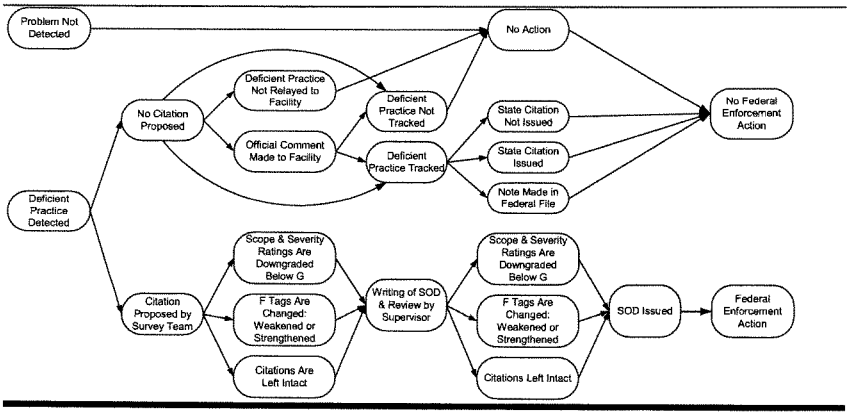
Table 4: Frequency of Omitted F Tag Citations per Facility

	# Of Facilities where this occurred	# of F tags per facility
Missed F tags	15	1 – 3 F tags
Comment for Deficient Practice	12	1 – 5 F tags
State Citation	3	1 F tag

3.1.2.3. Survey Practices

Observations of the surveyors in action during the survey offered a great opportunity to understand what happened behind closed doors, how decisions were made, and what factors affected the outcome of this decision process of the survey level. The citation decision-making process, as observed by the study team, is presented in Figure 3.

Figure 3: Survey Citation Decision-Making Process



3.1.2.4. Summary of Detection Issues

The case studies revealed common failures to detect deficient facility practice. It is difficult to ascertain exactly why the survey teams often failed to detect deficient practice. Surveyors were invariably diligent in their adherence to the complex and exacting procedural protocols. Nevertheless, very basic and openly practiced deficient care and documentation irregularities were often missed by a survey team. These omissions included insufficient repositioning of residents at risk for pressure ulcers; improper documentation; use of comfortable reclining chairs preventing rising etc. Standardized care plans instructing meaningless and/or ineffective interventions or failures to implement care plan interventions as instructed were often entirely missed or overlooked. These practices were not incidental or isolated occurrences; rather, they were common and affected many residents. At times more serious isolated incidents were also overlooked, as illustrated by the following passage:

> *Young male resident, recently re-admitted to the facility from the hospital where the resident had been treated for dehydration, was found restrained in bed, water pitcher out of reach. The resident had dry, furrowed tongue and was complaining of thirst. IO records required per facility policy had **not** been documented, since re-admission. CNAs, when questioned, were not aware of this resident's need for fluids and had not been assisting the resident with fluid intake. During the F tag meeting the survey team had discussed dehydration and found no problems.' FAC24SA1+NH1*

The data collector who observed this team on the last day of survey found the two surveyors primarily in the office completing record reviews. It is possible that this team had observed this resident at an earlier time during the survey, but the fact that no I&O records were available for this recently re-admitted bedfast resident should have reached the surveyors' attention and invoked an investigation. This survey team complained of insufficient time to investigate due to staffing shortages; however, not detecting this apparent and very basic deficient nursing practice implies problems with the investigative process.

Another factor potentially contributing to the surveyors' inability to detect deficient facility practices is the casual, often hurried and perfunctory manner in which some survey teams treat the *closed record review*. When questioned, subjects' responses revealed that many surveyors considered a closed record review to be meaningless, reasoning that a citation could no longer be of service to the resident once a resident had been discharged. Although these responses indicated a 'resident advocacy' attitude on the part of the surveyors, this is a rather limited view, since closed records could reveal care problems that may potentially affect a large group of current and future residents. Since the aim of the regulatory process is to create lasting and enduring compliance with minimum requirements *for all residents*, this narrow interpretation ignores the broader purpose of the closed record review and ultimately may fail to protect current residents.

Finally, deficient care practices were sometimes lost in the *investigative process* itself. Even though this happened infrequently, sometimes a line of inquiry was dropped before an informed decision was reached; a surveyor became distracted by other demands and/or

responsibilities, a surveyor/team leader was disorganized, incompetent and/or the investigative process was chaotic. Although most surveyors were professional and very competent, occasionally a surveyor was clearly lost and did not receive direction from either team members or the team leader to complete all investigations relevant to the decision at hand.

At times the surveyors were aware of the fact that they did not follow a line of inquiry or were unable to investigate all they would have desired. Three reasons were provided for these failures: 1) cumbersome paperwork; 2) shortened survey (often a full day less than the usual allotted time); and 3) manpower shortage. This last complaint was heard frequently and unsolicited in one state where a 'hiring freeze' clearly had placed a dent in the numbers of surveyors per survey.

3.1.3. Citation Decisions: to Cite or Not to Cite?

Survey teams at times made the decision not to cite a detected deficient practice. This decision not to cite occurred with relative frequency (*13/26*). Reasons for doing so varied but in general insufficient time, inadequate substantiation, and/or relative unimportance of the transgressions were quoted.

Identified but not cited deficient facility practices were often, but not always, communicated directly to the facility's management staff and at times were mentioned during the exit conference. Three states had semi-formal ways to deal with these non-cited deficiencies; in two states these communicated non-cited deficient practices were referred to as '*comments*' and ended up in the facility compliance file, while the other state referred to these practices as '*mentionable*'. Comments and mentionables were discussed as such during the F tag designation meeting, revealing that this is an accepted survey practice. In one particular instance, the surveyors reviewed a facility's compliance file during the F tag meeting, concluded that a specific deficient facility practice had not been commented on in the previous year; therefore, this year the facility could receive a comment instead of a citation. Surveyors when questioned indicated that these non-cited deficiencies were '*not significant enough to warrant a deficiency*'. Other reasons provided for not citing a detected deficiency were: a) 'there was no resident outcome'; b) 'the universe is not big enough'; c) 'the care needs of the residents are met'; and, d) 'the facility has identified the problem and is working on it'.

In one state this practice to '*comment*' occurred in a completely informal way, no records were kept and no tracking mechanism existed, still comments appeared in the form of advice and /or recommendations to the facility. When asked, the respondents stated that these deficient practices would have been A-level citations that required no Plan of Correction, therefore, they were not worth the paperwork and effort.

Surveyors expressed the belief that these comments and mentionable would encourage the facility to look at the issue and make the necessary corrections, a belief for which the case studies found no support.

One state cited some of the more serious deficient facility practices under State statutes, choosing not to cite the deficiency under a federal F tag. This alternate system of citing was believed to be less restrictive than the federal regulatory system, which they argued allowed citations to be issued with less paperwork, and, resulted in more stringent and effective enforcement. Investigating the States' regulatory practices were beyond the scope of this project; therefore no details were obtained. It should be noted that this alternate citing system decreased the number of higher-level federal citations even in cases were deficiencies were identified that were out of compliance with federal standards. In addition, the observed instances of this alternate citing practice had not resulted in any formally presented state citation two months after the survey.

3.2. Statement of Deficiency, Reflecting the Formal Survey Outcome

3.2.1. Citing: Regulatory Decision-Making Process

All deficient practices resulting in a citation are presented by F tag and S/S level on a Statement of Deficiencies *(SOD)* or 2567. The SOD represents the formal survey outcome and indicates the facility's compliance status according to the F tag at the highest scope and severity level. The citations on the SOD are the result of an extensive decision-making process that starts during the survey and is finalized at the SA.

The decision to cite is initially made during the survey activities. A citation decision is discussed with the survey team members during a general group session, the *F tag Designation Meeting*. During this session deficient facility practices are reviewed, and decisions are made with respect to issuing a citation.

Citations are specified by a federal regulatory tag, e.g., F 314 indicates that a facility did not meet all the federal requirements pertaining to the development and/or treatment of pressure ulcers. In addition, citations are assessed for scope and severity. A severity rating is assigned based on the extent of harm, whereas scope is determined based on the prevalence of the problem (how many residents were affected). Scope and severity designations range from A through J, with J indicating a more severe problem. For example, on this continuum a G-level citation indicates that an observed deficient practice was *isolated* (scope), but resulted in *actual harm* to one or more residents (severity). If, during the survey, the survey team decides to make a citation, decisions must then be made regarding the F tag, its scope and its severity. The resulting citation decisions are considered *preliminary survey findings*. These preliminary findings are presented to the nursing facility staff during the *exit conference*, a final open meeting with facility staff.

Following the survey, surveyors provide written substantiation for an F tag and the scope and severity level (S/S). This work is subsequently reviewed and scrutinized by supervisory SA staff and decisions are made about the appropriateness of an F tag and/or scope and severity level. Lastly a formal written document results, the Statement of Deficiency. The preliminary

survey findings may be revised and the survey citations on the SOD may look considerably different from the preliminary survey findings.

3.2.2. Statement of Deficiency Findings

Despite the survey flaws in detection and accuracy, many deficient facility practices become citations on the SOD. The Statements of Deficiency for the 26 case studies revealed considerable variation in frequency of citations (Table 5). The total number of citations per case study was as low as one citation (in *two case studies*) and as high as 21 citations *(in one case study)*. However, most facilities averaged between 4-10 citations.

Table 5: Citation Frequency per Case study by State

	State 1 (N = 7 Case Studies)	State 2 (N = 4 Case Studies)	State 3 (N = 8 Case Studies)	State 4 (N = 7* Case Studies)	All States
#of citations					
1 – 3	1	1	0	1	3
4 – 6	1	1	4	1	7
7 – 9	1	1	3	1	6
10 – 12	1	1	1	2	5
13 – 15	3	0	0	0	3
16 – 18	0	0	0	0	0
19 – 21	0	0	0	2	2
Total	7	4	8	7	26

** includes complaint investigation*

Scope and severity designations ranged from B to IJ *(Immediate Jeopardy)* (Table 6). In all states the majority of citations were issued at B, D, and E levels. No A-level citations were given for any case study facility in any state. A–level citations do not require any enforcement actions, therefore, it was considered *'not worth the effort'* to write up these citations. The majority of S/S designations were at the D-level; very few citations were issued at or above the F level. This is likely related to the fact that higher-level citations (beginning with F) may change a facility's compliance status. In the case of issuance of an F tag at or above the F-level, the facility's compliance status may change from *substantial* to *substandard* compliance. G-level citations carry even more severe enforcement consequences and as such are an undesirable outcome for most facilities. Ten G-level citations were issued for seven case studies. The majority of Gs occurred in state 4 (5 Gs) and none were issued in state 2. Two of the case studies with G-level citations received multiple Gs on the SOD, respectively, three and two each. Immediate Jeopardy citations, which put a facility on a fast track to closure unless immediately corrected, were issued in three facilities in three different states.

Table 6: Number of Citations by Severity and Scope Levels in each state.

S/S level	State 1	State 2	State 3	State 4

B	23	1	1	8
C	4	1	1	0
D	25	9	26	39
E	7	6	12	16
F	0	1	3	4
G	1	0	4	5
H	0	0	0	0
I/J	0	1	1	1
K	0	0	0	0
L	0	0	0	0

* Includes complaint investigation

3.2.2.1. Discrepancy between Preliminary Survey Findings and Statement of Deficiency

Of the 25 case studies, 7 showed no change from exit conference to SOD. However, '*downgrading*' of the scope and severity level occurred in 14 cases (12 of which involved complete removal of an F tag) and upgrading occurred in 5 cases. Thus, discrepancies between the preliminary survey findings presented during the exit-conference and the SOD occurred in a total of 18/25 case studies. (Note: both an upgrade and a downgrade occurred in one case study; resulting in 19 changes per 18 case studies).

It was apparent from the case studies that the revisions on the SOD were not random; rather a clear trend emerged toward minimizing the preliminary survey outcomes by lowering the scope and severity level and/or removing certain F tags altogether. Moreover, the frequency of downgrades per case study was considerably greater than the frequency of upgrades, again revealing a tendency to minimize the preliminary survey findings. Additionally, the downgrades were in general away from G. It must be emphasized that in almost all cases of change on the SOD the data collectors agreed with the surveyors' original preliminary survey findings.

If one arrays the proportion of nursing homes receiving a G or higher level deficiency by quarter, there was a sharp downward trend beginning in January 2000, almost coincident with the introduction of the Double-G policy in January 2000. This policy required that all homes receiving two successive G or higher deficiencies had no opportunity to correct the deficiency and had to be referred to the regional office for a sanction. Since it is improbable that the quality of care in the nursing homes precipitously improved or declined, this change is likely due to survey agency behavior and not to any real change in the quality of care. It is likely that Survey Agencies were trying to avoid the referral process, an inference which is supported by these case studies. Thus, there may be inherent (albeit unintentional) incentives to downgrade and this is one such example of an incentive.

3.2.3. Citing Practices

3.2.3.1. Weakening- Strengthening of F tags

This is a relatively infrequent occurrence (5/25) happening mostly at the survey level although occasionally this occurred at the SA level. Weakening or strengthening involved the selection of an F tag that carries less/more weight either based on the facility's deficiency history, or in relative weight in the federal regulatory system. Additionally, one other way to strengthen a particular citation is by tagging it under a variety of F tags, each bearing some relevance to the deficient practice. The decision to weaken or strengthen an F tag was often, although not always, deliberate; however, the study could not discern a particular direction. In other words, weakening of an F tag occurred as frequently as strengthening. The following case illustrates an example of a chaotic survey by an independent survey team unwilling to assist one of its team members in reaching a conclusive citation with respect to pressure ulcers:

> *'76-bed facility surveyed for its annual re-certification survey revealed a high incidence rate of facility acquired pressure ulcers, which the team investigated. During observation one resident had been found soaking wet. A medical record review revealed that this resident was treated for a 'diaper rash'; in addition, the records recorded repeated skin breakdown, which were documented as excoriations. The investigating surveyor was disturbed by these findings and had wanted to cite the incident under f 314 for failure to prevent pressure ulcer, but could not figure out how. The team did not offer assistance to reach a conclusion. The surveyor decided to cite under F316, failure to provide bladder training. Subsequent observations by the data collector revealed that the facility failed to provide its residents with the most basic preventive pressure ulcer care; keeping incontinent residents clean and dry and repositioning of mobility impaired residents. Study observations indicated that residents were left unchanged and without repositioning for stretches of six hours at a time.' FAC13 SA1 and NH1*

A rationale for strengthening an F tag was sought in the following example where the nursing home did not seem to understand the severity of their transgression, nor could the severity be elucidated through the S/S level. The team sought ways to signal to the facility their deep concern regarding the facility's practice by reviewing all regulations, federal and state, relative to the transgression in an attempt to issue more than one citation, '*double dipping*'.

> *'Mid-size facility (>100 beds) visited for annual re-certification survey by a team of 5 surveyors, including 3 RNs. The Team in obtaining a list of discharged residents noticed that one resident had no indication as to discharge location, and in questioning that omission, facility staff had replied, "He is missing, but he left his jacket here so we think he may be back." This remark sent the survey in a tailspin, the incident had taken place one month prior and facility staff did not know of the resident's where abouts. An Immediate Jeopardy (IJ) citation was considered and the survey was extended. As the details of the incident emerged, the team's opinion shifted. The resident had been alert and oriented, had signed his own admission agreement with the facility and was deemed capable of making his own medical decisions. Nonetheless, the facility had failed to report this incident to the appropriate governing agencies, had failed to conduct an investigation into the matter and therefore had failed to protect the resident from the potential for harm. The Team remained in constant communication with the SA and it became apparent that SA supervisory staff would not support an IJ citation; some team members experienced this as a total lack of support. When the Team finally sat down to make citation decisions, the discussions often circled back to abuse and neglect. The team members*

had reviewed the State Operations Manual extensively and tried to fit this incident under many F tags including all abuse tags and all tags related to discharge or transfer in an attempt to find more than one F tag that was appropriate to the situation and would "stick." Only F223 seemed to fit and the incident was cited as D; an isolated occurrence with the potential to cause more than minimal harm. This relatively benign S/S level did not express all team members' view of the incident and their perception of the facility's "lackadaisical" attitude towards it. The occurrence of the missing resident was a difficult situation that was not resolved to everyone's satisfaction.' FAC29SA1

The practice of weakening or strengthening seldom provoked this much discussion or disagreement among team members and/or with their supervisors.

3.2.3.2. *Downgrading*

In contrast, designation of severity and scope level was often subjected to spirited discussions and extensive deliberations during the survey and called for serious scrutiny by supervisory staff at the SA. These deliberations and reviews often resulted in *'downgrading'* - the selection of a S/S level lower than appeared warranted on first review. Downgrading was commonly done at both the level of the surveyor and supervisory *(14/18* case studies). Downgrades often involved more than one citation, with as many as six downgrades executed in one case study. Downgrades were focused mainly around G-level citations, representing isolated cases of actual harm resulting from a deficient practice. Downgrades occurred from various origination scores, such as from G or E; the dominant downgrade was away from G. Comparatively, upgrades occurred relatively infrequently (in only *5/18* case studies), and reached the level of a G-level citation only once *(1/5* case studies).

The following case is representative of the downgrading process at the survey level.

'During the F tag designation meeting the team leader stopped to pause after one of the surveyor trainees indicated that she had an actual harm citation. The team leader, placing her face in her hands and taking some time to think, finally commented: "Now let's stop for a moment and think this through. Do we want to cite actual harm? What are the extenuating circumstances? How could we explain this differently, what could be other reasons?" The trainee eloquently stated her position to cite a particular instance at a G level. Her arguments were clinically sound and, from a regulatory perspective, warranted a G. The discussion was lengthy and was only brought to a close when one of the surveyors suggested that the team could not make a determination of actual harm since surveyors did not have the authority to diagnose. Therefore, the incident (discharge of an increasingly agitated resident to a psych unit following delayed medication for a UTI) that had resulted from the facility's deficient care could not be assessed as actual harm. The decision was made to cite at a D-level.' (Aborted site 7)

This example illustrated two aspects of survey level decision-making that were apparent in multiple cases: a) the tendency toward increased questioning once a G-level citation was suggested; b) socialization of trainees to make lenient decisions. Trainee surveyors brought a fair share of citable events to the F tag designation meetings, where they were subsequently convinced to cite at a lower level or not cite at all. Trainees often argued vehemently, and to the observer's eye with clinically sound reasoning, only to meet resistance. In general, a trainee

ultimately deferred to other team members, who inevitably argued against citing. In these discussions a tendency towards leniency on the part of the more established survey members was apparent and trainees were socialized into this tendency through the interaction that took place between the team members.

3.2.3.3. *Dropping an F tag*

Removal of an F tag from the SOD or *'dropping'* an F tag was not an unusual occurrence, *(11/18)*. These removals were in addition to the downgrades that may have occurred at the same site. *Dropping an F tag* occurred mostly as a result of supervisory scrutiny. The following case involved three G-level citations removed from the SOD following supervisory review.

> *'An 81- bed facility, surveyed for annual re-certification by a team of 4 RNs, was presented at the exit conference with 12 preliminary citations, including 3 G-level. The survey had been shorter than usual by one day due to surveyor training activities at the SA. The team had found many deficient facility practices, three of which were scored at G-level including F 309, F 314 and F 325. The RN responsible for the 3 Gs had been supported in her conviction to cite at G by one of the RN members, however, the team leader had expressed no opinion. The study's independent assessment strongly agreed that indeed the facility's practices had contributed to the development of several pressure ulcers (F 314); overall decline in status of one resident (F309); and several incidences of weight loss (F32) and had cited these F tags at G, concurring with the survey's preliminary findings. The data collector remarked that especially the facility practices with respect to repositioning residents left a lot to be desired. Regular observations showed a failure to reposition residents every few hours according to facility policy and individual care plans. Subsequently, all G level citations were dropped on the SOD. Upon inquiring during interviews with SA staff, it had been the supervisor's decision to remove all G-level citations: two were removed because of insufficient evidence; one F tag was removed because the case was not sufficiently made that actual harm had occurred. Despite the supervisor's different perspective, the surveyor responsible for the citation held strong to her belief that in each of these F tags a G had been warranted.' FAC49 SA1, NH1, SA2*

The reasons indicated for dropping these three F tags were by no means unusual. Similar rationale was frequently given for downgrading. The source of the disagreement was the Actual harm criteria, which seemed to generate ongoing debates that could not be resolved.

3.2.3.4. *Actual Harm Criteria: a Moving Target*

The case studies revealed that *actual harm criteria* were not consistently used between the state and district offices, or among SA staff. Actual harm citations start at G level; a G –level citation involves actual harm to at least one resident as the result of a deficient facility practice. Harm criteria were applied differently depending on the circumstances.

The most frequently cited requirement for an actual harm citation was *function loss*. In several interviews, SA staff mentioned *severe function loss* (rather than *function loss*) as a necessary requirement to cite at G-level. Additionally some SA staff indicated that the function loss had to be permanent, irreversible, and include pain and/or discomfort. The following excerpt illustrates one survey team's application of the actual harm criteria.

'Team leader calling out F324 during F tag designation meeting; following interaction ensues:
RN1 This is resident #1. She fell out of her chair and broke her cheekbone. They had no measures in place to prevent her fall. She had a history of falls at home. She was assessed but they (the facility) did nothing. They did have a low bed. Afterwards they tried to do everything for fall prevention. She took the lap buddy off. Since then we can't say the facility didn't try. Citation for F324 D.

Note data collector: later I ask RN1 why they didn't cite at a level G since the resident broke her cheek bone as a result of the fall. RN1 stated the fracture healed and now the resident is better. She didn't lose any function.' FAC13 SA1

Two factors are evident from this discussion: 1) pain and/or temporary function loss were not considered for the S/S level; 2) facility failure is not raised as a contributing factor.

The application of different criteria at different times created the appearance of reluctance to cite deficiencies at an actual harm level. It was obvious that actual harm criteria were elusive and little guidance was offered to surveyors as to what exactly constituted actual harm. Surveyors expressed their frustration at times as illustrated by the following interview excerpt:

'RN1: One thing that I don't agree with is I've wanted to write harm citations but CMS and my supervisors say it is not harm unless there is loss of function.
Data collector: What do they mean?

RN1: A permanent downhill course of permanent harm. For instance somebody can keep falling and get bruises but that is not harm because their function is still the same. I had a case where I noticed a resident that was not doing well. It turned out that he had a UTI and they hadn't assessed him for it. He was having recurrent UTIs and I felt it was harm. But I went to my supervisors and CMS and they said it wasn't. Then a short time later he died. If that's not harm I don't know what is.' FAC13 SA1

In addition to unclear and inconsistent application of actual harm criteria, the interviews also revealed that the criteria for a citable offense in the case of actual harm were not used consistently. The confusing factor appeared to be the negative resident outcome, such as a pressure ulcer. A pressure ulcer per se is only considered a citable offense if/when deficient facility factors can be established as a contributing factor in the development of the pressure ulcer or its failure to heal. However, when asked, SA staff readily indicated a variety of reasons why facility failure could not be established as the precipitating factor. For example, SA staff explained that a facility-acquired pressure ulcer should be excluded as an actual harm citation in the following situations: a) the wound is healing and therefore treatment is adequate; b) the facility has recently changed its pressure ulcer policy and therefore is complying with the regulations; c) management staff has identified the problem and is working on solutions; d) stage 1 and 2 pressure ulcers involve little healing time and/or discomfort. It is important to note that in all these justifications for not citing at an actual harm level, the most important issue (*avoidability of the negative resident outcome,* and by extension, responsibility of the facility) was not addressed. By turning the attention to the facility's ameliorative actions following pressure ulcer acquisition, the teams avert attention from the issue of avoidability and responsibility. It

seems irrelevant whether a facility is able to heal a pressure ulcer if deficient facility practices contributed to its development. Equally irrelevant are the healing time of a stage 1 or 2 pressure ulcer, or the relative intensity of discomfort in determining faulty facility practices.

The repercussions of unclear criteria were obvious in missed citations, downgrading, and F tag removal. In addition, the act of downgrading and dropping F tags contributed to the nursing home's perception that certain deficiencies should not be cited, setting the stage for a potential IDR.

> *'Just prior to a major holiday weekend, a midsize, multi chain facility is surveyed for annual re-certification. Shortly into the survey, a glaring problem is noted with pressure ulcers and one resident with multiple pressure ulcers is selected for the survey's resident review. This resident is subsequently discharged to a nearby hospital for 'wound debridement', leaving the team with a half-day of observations and an individual resident record review. Although there are clear indications that the facility provides deficient pressure ulcer care citable under F 314, the surveyors, during the F tag designation meeting remain on the fence. They mention that they do not have enough time to gather documentation and do observations. In addition, they are overwhelmed by the quantity of citations (this is a shortened survey, 3 days instead of the usual 4 because of an in-service day); and, the surveyors are eager to wrap up because of the upcoming holiday weekend. During the "write-up" of tags, the citations are watered down; one RN is ill, the second RN is concerned because there are co-morbidities for her case and she wants a cite that is "plain as the nose on your face." In addition, the supervising SA staff is afraid of losing in arbitration. F 314 is dropped entirely. The independent study assessment reveals that the records provide enough evidence for a harm citation. In an unexpected turn of events, a complaint is levied against the facility for insufficient pressure ulcer care and the complaint investigation substantiates the complaints and cites F 314 at G. The nursing home now feels that there is a case for an Informal Dispute Resolution because the two SA assessments (survey and complaint investigation) are contradicting. Ultimately the facility loses this argument and the IDR maintains the complaint investigations original F 314 at G.' FAC04*

3.2.3.5. *Underreporting; Causes and Consequences*

Underreporting was a common practice taking on many forms for the case studies. The Statement of Deficiencies as the formal representation of a facility's compliance often portrayed the facility in a better light. The incentives to underreport were ample. The most frequently mentioned reasons for downgrading and/or dropping an F tag were insufficient supporting evidence to maintain the citation, closely followed by the need to be able to uphold a citation under the scrutiny of *Informal Dispute Resolution.*

Data collectors invariably agreed with the original survey citation, which could conceivably (but not necessarily) mean disagreement with the supervisor's assessment that insufficient corroborating evidence was presented to support the citation. Data collectors on several occasions commented that surveyors spent ample time reviewing records and documenting. This may have been at the expense of direct observations of resident care, although the study cannot be definitive on this issue, since the data collectors were only on-site during one day of the survey. Yet the independent study assessment often indicated that direct observations over

an extended period of time could have easily yielded sufficient evidence to support the original citation.

Surveyors frequently mentioned that insufficient time or a shortened survey had hampered their efforts to obtain adequate supporting evidence. Surveys are complex investigations and surveyors must meet many procedural demands within a limited time frame. Meeting all these demands while supporting multiple citations made it difficult to make all citations *'stick'*. In addition, higher-level citations were said to be more easily singled out for IDRs, and therefore were held to higher standards of evidence. This could explain the tendency to downgrade Gs level citations. Several remarks, such as *'the surveyors should have focused on the Gs rather than chasing all these other F tags'*, alluded to this fractured focus as a possible explanation for failures to provide sufficient supporting evidence. In addition, an off-hand comment that: *'Gs are mostly the result of a complaint investigation'* pointed in a similar direction, as supported by the last example.

Thus, the standards for supporting evidence were high and often impossible to meet given the constraints of the process. However, the consequences of the resulting practice of downgrading and F tag removal eroded the credibility of the surveyors, placed the legitimacy of the survey outcome at stake and had the opposite effect of what the regulation hoped to accomplish. In the words of one of the data collectors:

> *'The management's perception of the survey team having a "vendetta" against the home is substantiated in their minds by the fact that the State dropped the Gs. Any hint that there may have been substandard care is dismissed because the credibility of the surveyors is not there.' FAC49 SA2*

3.3. Enforcement Actions

3.3.1. CMS Enforcement Regulations: Remedies and Penalties

The enforcement process involves the selection and potential execution of enforcement actions. Enforcement actions are determined based on the formal survey outcome reflected on the SOD.

Enforcement actions are sanctions, penalties or remedies invoked to encourage a facility to return to compliance within a specified timeframe. The SA selects all enforcement actions and presents these as *recommendations* to CMS and the facility. Enforcement decisions are strongly guided by federal regulation.

CMS' enforcement actions are classified in three main categories increasing in severity, each containing several alternative enforcement options: category I, including *Directed In-Service and Directed Plan of Correction;* category II including *Denial of Payment for New Admissions* and *Civil Monetary Penalties;* category III, including *Termination* of facility (see CMS enforcement grid). The SA in selecting an enforcement action ***must*** select one remedy from a mandatory category

and ***may*** additionally select from an optional category as well. Mandatory enforcement actions include:

- *Plan of Correction (POC)* for all facilities with deficiencies warranting an SOD
- A *Civil Monetary Penalty (CMP)* for all ≥ G-level citations
- *Immediate Jeopardy (IJ)* cases which must receive a per instance CMP

The SA in selecting an enforcement action has some maneuverability; the mandatory category has several alternatives to choose from. In addition, the SA can opt to select additional enforcement actions from the optional category.

Recommended enforcement actions, unless mandatory, will be *executed* only when the facility does not comply by a specified date. CMS mandates *Denial of Payment for New Admission (DPNA)* when a facility has not reached compliance within 3 months after survey date, and termination of the facility if compliance is not achieved six months following original survey date.

3.3.2. Enforcement – Case Study Findings

All 25 case study facilities were mandated to submit a *Plan of Correction (POC);* eight facilities *(8/25)* were additionally subjected to enforcement actions consisting of a monetary action of some kind. These additional enforcement actions consisted of *Civil Monetary Payments (CMPs)* for eight facilities; of which two facilities incurred an additional *Denial of Payment for New Admissions (DPNA).*

Civil Monetary Penalties were levied either *per instance* or *per day.* CMPs *per day* were mandated in seven facilities (7/8); of these six facilities had at least one G level citation and one facility had 21 citations (all <G). In the case of the last facility, it was clearly the high number of citations that provoked the CMP, since no G citations were made. Per day fines ranged from $50 to $700/per day for 30 – 60 days. In addition to CMPs per day, CMPs *per instance* were mandated for three facilities *(3/8),* all of which had been issued an *Immediate Jeopardy* citation. In contrast to the *per day* fines, the *per instance* fines ranged from $3,500 to $7,500.

Most SA *recommended* enforcement actions were never executed *(17/25);* for these seventeen facilities only the federally mandated Plan of Correction went into effect.

Table 7: Executed Enforcement Actions

Enforcement	State 1	State 2	State 3	State 4	Occurrences
POC	7	4	8	7	26 *
CMP p/day	1	0	2	4	7
CMP p/instance	0	1	1	1	3
DPNA	0	0	0	2	2

* Includes complaint investigation

3.3.2.1. Relationship of Statement of Deficiency to Executed Enforcement Actions

The relationship between the final SOD and executed enforcement actions was surprising in that facilities with very different SODs ended up with very similar enforcement actions; either a POC or a CMP. Only one case study facility had a DPNA executed.

Facilities with very different citation rates ended up with very similar enforcement actions; e.g. one facility with 15 citations and one facility with 5 deficiencies were both subjected to the mandatory POC, but no other enforcement actions were executed. These two facilities had a similar S/S distribution range in common, each ranging from B – E.

In addition, facilities with different citation rates ***and*** additionally different S/S distributions could also end up with similar enforcement actions as long as the S/S was below G. One facility with 8 citations (4 D; 3 at E; 1 F) and a facility with just 1 D-level citation were each issued a mandatory POC, no other enforcement actions were executed.

Facilities with G or higher-level citations were ***all*** subjected to similar enforcement actions; monetary penalties of some kind. Citation rates could be comparatively low or high as long as a facility had issued a citation at G-level or higher sanctions were executed. Only two facilities did not fit this pattern: 1) one outlier facility with a higher than usual citation rate (21) was subjected to a daily penalty, despite the fact that the highest scope and severity level reached only E; 2) one facility that had not reached substantial compliance by the 3 months timeline had DPNA imposed.

Table 8: Relationship between SOD and Executed Enforcement Actions

		Statement of Deficiency							Executed Enforcement Actions			
Case Study ID	# of Cites	B	C	D	E	F	G	IJ	POC	CMP p/day	CMP p/instance	DPNA
FAC24	14	8		3	3				YES	NO	NO	NO
FAC43	13	3		8	2				YES	NO	NO	NO
FAC64	10	5		5					YES	NO	NO	NO
FAC91	9	2	2	2	2		1		YES	$100 (35 days)	NO	NO
FAC13	2		1	1					YES	NO	NO	NO
FAC97	15	5	1	8	1				YES	NO	NO	NO
FAC96	4		1	2	1				YES	NO	NO	NO

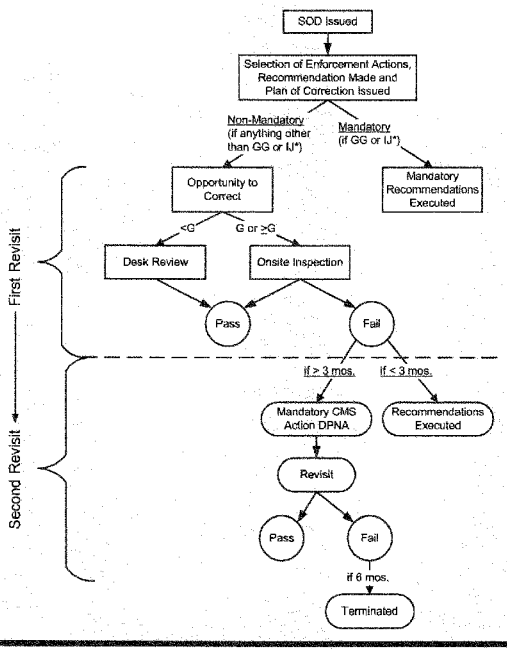
FAC94	9		1	5	3			YES	NO	NO	NO
FAC63	5			4	1			YES	NO	NO	NO
FAC18	10			6	3	1		YES	NO	NO	NO
FAC29	4	1		2	1			YES	NO	NO	NO
FAC01	4			2	2			YES	NO	NO	NO
FAC90	8			7		1		YES	NO	NO	NO
FAC21	9			6	2		1	YES	$100 (35 days)	$4,000 (1 instance)	NO
FAC49	6				1	2	3	YES	$100 (60 days)	NO	NO
FAC49	10	4		2	2	2		YES	NO	NO	NO
FAC08	10	1		7	2			YES	$100 (35 days)	NO	YES (5 days)
FAC17	4			1	1		1	1	YES	$150 (30 days)	$3,500 (1 instance)	NO
FAC04	21			14	5	2			YES	$50 (60 days)	NO	NO
FAC47	8	2		2	3		1		YES	NO	NO	NO
FAC68	19	1		13	3		2		YES	$700 (35 days)	NO	YES (1 day)
FAC62	4		1	1	1			1	YES	NO	$7,500 (1 instance)	NO
FAC11	5			3	2				YES	NO	NO	NO
FAC03	8			4	3	1			YES	NO	NO	NO
FAC66	1			1					YES	NO	NO	NO

In summary, few case studies had enforcement actions imposed and all but two of the executed enforcement actions consisted of a penalty. A consistent relationship between citation rates and distribution of S/S level was non-existent unless the S/S was a G –level citation or higher which corresponded with the CMS mandatory requirements.

3.3.3. Enforcement Practices

Two CMS mandates heavily influence the selection and execution of enforcement actions: 1) the *'Opportunity to Correct'*, a privilege dispensed to facilities at the discretion of the SA; 2) the S/S level as the most important determinant for enforcement actions (Figure 4).

Figure 4: Federal Enforcement and Compliance Process



3.3.3.1. Opportunity to Correct

The SA is vested with the discretionary authority to grant a facility an '*Opportunity to Correct*', something that is frequently administered. Twenty-two (22) of 25 case study facilities were granted an Opportunity to Correct. The three facilities that were excluded from this privilege had an IJ citation issued.

The Opportunity to Correct transformed a non-mandatory enforcement action into a future threat, an encouragement to accomplish corrections as demanded by regulation within the specified timeframe. Therefore, a non-mandatory enforcement action functioned as a deterrent rather than an immediate remedy or sanction. It allowed a facility some breathing room to comply; however, if the facility failed to institute appropriate corrections in a timely fashion the recommended enforcement actions would be activated. Facilities and management staff responded very differently to this threat: from complete indifference, through fear for potential

financial, employment or census repercussions, and/or fear for losing personal or facility reputation.

For the 25 case studies only one facility lost its Opportunity to Correct due to non-compliance within the regulatory time frame.

> *'In this particular case, the facility had claimed to be in compliance by the specified date, however the State having inspected this facility already once on a revisit to verify actual compliance, was unable to meet the procedural guidelines for a timely second visit. The SA claimed insufficient manpower. The facility paid the price in an enforcement action of five days denial of payment for new admissions (DPNA). According to the data collector, this was a very high price to pay indeed, even though, in her assessment, the facility had by no means achieved the full regulatory compliance they claimed. However, adding financial hardship to this already financially troubled facility rather hindered, than assisted the facility in establishing the goal of regulatory compliance and improving its quality of care.' FAC04*

This example was evidence of some of the regulatory constraints to levy sanctions within very specific guidelines and the difficulty in selecting enforcement actions appropriate to the specific nursing home's situation. In this case, quality of care did not improve even though the facility tried. Unfortunately the mandatory enforcement action of DPNA did nothing to assist the facility improve its quality of care.

In summary, very few facilities were subjected to any enforcement actions, other than the mandatory POC, due to having been granted an Opportunity to Correct. Although that provided the facility a real chance to address problems, it creates a burdensome revisit process for SAs that must be extremely vigorous or, the Opportunity to Correct becomes synonymous with no citation.

3.3.3.2. Selecting Enforcement Actions: Exclusivity of S/S Level

SODs vary considerably, yet enforcement actions show little variation other than what is mandated by regulatory statutes.

For the case studies executed enforcement actions involved only monetary penalties. Selection of minimal enforcement actions was by regulation exclusively determined by the highest S/S level citation in the SOD. However, the SA or the Regional Office can in addition apply a number of optional remedies. Although a facility's deficiency history was mentioned by many SA respondents as a factor in the selection of enforcement actions, this was not apparent from the case studies.

The exclusivity of S/S level as determinant for selection of enforcement actions had the rather curious consequence that facilities determined to have only minor infractions according to the SOD faced similar enforcement actions as facilities that were determined to be out of compliance with respect to many federal requirements. In most case study facilities this meant

no enforcement, other than the POC. This is shown in the following example of two facilities contrasting considerably in their final the SOD:

> *'The annual re-certification survey of facility I resulted in two citations including: F314 D for failure to implement a toileting program for one alert and oriented resident; F371C unsanitary conditions in kitchen. The recommended enforcement actions consisted of a Directed In-Service in case the facility was not found in compliance within 30 days after the survey. Facility returned to compliance within designated time frame and no enforcement actions ensued.*
>
> *The annual re-certification survey for facility II resulted in 13 citations including among others F221 D for failure to obtain orders for a waist restraint; F 309 failure to administer pain medication as ordered; F314 for failure to provide an alternating pressure pad as ordered to a resident with multiple pressure ulcers; F317 for failure to prevent ADL decline; and, F323D failure to ensure an accident free environment for all residents. The last citation showed several occurrences each observed during the survey, one resulting in minor injuries (abrasions). The recommended enforcement actions consisted of a Directed In-Service in case the facility was not found in compliance within 30 days after the survey. Facility returns to compliance within designated time frame and no enforcement actions ensued.'*

For these two facilities, the number of citations did not influence the selection and execution of enforcement actions. This was in fact the case for the majority of case study facilities. Only once did the high number of citations *(21)* impact the selection of enforcement actions and a non-mandatory CMP was enforced. This facility could have escaped the execution of this penalty altogether since it had been granted an Opportunity to Correct, were it not that the deadline for implementation of the corrective actions had not been met.

The highest S/S level citation determined the selection of the enforcement action, however, the number of citations at the highest S/S was equally irrelevant. For enforcement purposes it did not matter whether one, two or three citations ended up with the highest S/S level. No enforcement actions followed in case of multiple citations under E or F as the highest S/S level. In cases of G-level citations the executed penalties were similar per state: either a CMP of $100 per day for facilities with one or multiple G-level citations in one State; or, a CMP amount slightly higher in another State. In conclusion one can say that the total number of citations and distribution of S/S level were relatively unimportant.

3.3.3.3. Repeat Deficiencies

Repeat deficiencies, the same F tag citations occurring in two consecutive compliance cycles, were a major problem for the case study facilities. The majority, thirteen out of the twenty case study facilities for which the study had data revealed a repeat deficiency in one of the study F tags. This number increased to 19/20 when a two-year history was used for comparison; i.e. only one skipped compliance cycle.

The study established repeat deficiencies for the case studies by proxy, through the CMS Nursing Home Compare site. This CMS site does not reveal deficiencies by actual F tag, and as

such the study review was not complete. However, interviews with SA staff were used to corroborate a repeat deficiency for specific case study facilities. Most, but not all, respondents were willing and/or able to provide the study with answers. In general, the SA responses concurred with the study findings that repeat deficiencies occurred frequently.

Surprisingly repeat deficiencies did ***not*** impact enforcement actions for any of the case studies; neither was the Opportunity to Correct withheld, nor were more severe sanctions selected. Even though several of the case study facilities with repeat deficiencies had the Opportunity to Correct withheld and were subjected to sanctions, these sanctions were imposed because of the S/S level. The facility's deficiency history may have factored in but was not the cause for the imposition of sanctions as illustrated in the following interview excerpt:

> *'Data collector: This facility has had several repeat deficiencies. How often does a facility get the opportunity to correct? How will similar deficiencies be prevented in the future?*
> *Licensing Officer: This happens often because they (the facility) just put a Band-Aid on the problem and then go back to their old ways. It might be because the person who fixed it leaves and there is no continuity. Or there is a change in upper management and the replacements don't know the history. I don't always have a lot of recourse because once the cycle is closed it is done. In the worst cases I can do monitoring visits to try to be sure the correction sticks.' Licensing Officer SA3 FAC04*

This facility had 21 citations and because of that high quantity a per day fine of $50 was imposed. The SOD indicated a citation for F 314 because of inadequate assessments and documentation. The independent study assessment indicated a severe problem with pressure ulcer prevention and treatment that warranted an actual harm citation at F314G. The facility had been cited for PU in two consecutive compliance cycles in the last three years prior to this survey. An obvious recurring problem with pressure ulcer care, yet no enforcement actions related to it.

When questioned, many SA staff indicated that repeat deficiencies were of great concern to them, and felt in general that the enforcement was inadequate in dealing with repeat deficiencies. Repeat deficiencies impact enforcement actions ***only*** in cases of: a) *'double G'* citations, a G-level citation for the same F tag in two consecutive compliance cycles; or, b) a F level citation under specific F tags issued in two consecutive compliance cycles. SA staff expressed concern, frustration and in general felt powerless to influence the situation as revealed in the following interview excerpt:

> *'If a repeat deficiency occurs we will look at the situation more closely.....focus on it...enforcement actions could be different depending on the scope...possibly a directed in-service or a directed POC (I don't like a directed POC...time constraints...).....even a monitoring follow up visi....we can do a revisit without a G at the discretion of the surveyor...the providers don't like it.' Licensing Officer, SA2 FAC91*

In this case, no enforcement actions were executed because *'. the ulcer is healing...'*. It was disheartening to see that so many citations could be repeated, placing the residents at risk on a recurring basis.

3.3.3.4. Plan of Correction: Most Important Enforcement Tool

All facilities receiving a Statement of Deficiency must at minimum submit a POC. This fact, in combination with the finding that most case study facilities were granted an Opportunity to Correct, elevated the mandatory Plan of Correction (POC) to one of the most relied upon, and therefore, most important enforcement tools at the SA's disposal. The POC is a facility document outlining for each cited F tags, all the corrective steps that the facility will follow to return to regulatory compliance by a pre-determined date. The POC is reviewed for compliance by the SA.

3.4. Revisit: Compliance Determination

3.4.1. Revisit Guidelines

The final step in the enforcement process is the determination of a facility's compliance following implementation of the POC. Compliance is determined through a revisit, a rather disguising term since the revisit may consist of either a desk review of the POC, or, an actual on-site inspection at the nursing home.

A desk review, also aptly named a *'no visit revisit'* or *'paper compliance'* consists of a review of a facility's Plan of Correction. The review involves an assessment of the suggested corrective actions with respect to four required elements:

- accomplishment of corrective actions for all residents affected by the deficient practice
- identification of residents at risk to be potentially affected by the same deficient practice
- prevention of recurrence of the deficient practice
- presence of a plan monitoring facility performance towards sustained compliance

If for each F tag the POC complies with these four elements, the POC will be approved and the facility is considered back in substantial compliance.

Alternatively, a revisit may consist of an on-site inspection to the facility conducted by one or more surveyors. An on-site revisit closely resembles a standard annual survey on a smaller scale. Revisit investigations are focused on but not limited to the original survey citations; if a new deficient facility practice presents itself it will be cited. Hence, re-visits may result in the same or additional citations as the original survey. On-site inspections are required for any ≥G-level citation.

3.4.2. Revisit Findings

Most case studies *(16/26)* compliance was determined through a desk review; on-site inspection took place in the remaining ten cases. Although all states conducted some revisits through an on-site inspection, the majority of these inspections *(6/10)* were conducted in one state. In this

state on-site inspection revisits were conducted for all facilities having incurred a ≥C citation. This is a more stringent requirement than mandated by CMS, which requires on-site inspections for any ≥ G citation.

Facilities were rarely found in continued non-compliance following a revisit. Only a few facilities with on-site inspections *(2/10)* were not cleared on first revisit; a second on-site inspection took place and subsequent compliance ensued. Both these cases occurred in the state with the highest number of on-site inspections. ***All*** desk reviews were cleared for compliance on first revisit.

Table 9: Revisit Frequency and Compliance Determination by State

Re-visit	State 1	State 2	State 3	State 4
Desk review	6	3	6	0
Timely approval	6	3	6	NA
On-site Inspection	1	1	1	6
1st time approval	1	1	1	4
2nd time approval	NA	NA	NA	2

The differences between the states in the case studies is clear with stricter standards in determining compliance for one of the four states (state 4). On-site inspections after all include verification of actual implementation of the corrective actions suggested in the POC; a desk review can only scrutinize the Plan itself. In most states the effect of the enforcement process was diminished because almost every facility was given the opportunity to correct and approval was then granted based on desk review of a POC.

3.4.3. Enforcement Practices

3.4.3.1. Paper Compliance – a Matter of Trust

Mostly, although not always, the POC was reviewed by one of the original survey team members, but not necessarily the surveyor who had issued the original citation. Desk reviews were often perfunctory reviews, assessing whether the presented corrective actions met the four required elements. Desk reviews always resulted in timely approval of the POC, and although surveyors may not approve a POC on first round, the Opportunity to Correct was never at risk.

Desk reviewers were at a clear disadvantage in assessing compliance when compared with on-site inspections; actual implementation of the corrective actions presented in the POC could not be verified. Most reviewers were keenly aware that '*the POC is just paper, and.... a piece of paper will not tell you compliance*'. Desk reviewers did at times demand amendments to the POC or required evidence to corroborate the veracity of claimed implementation; yet when questioned

surveyors admitted that they had to believe the facility *'at their word'*, or simply stated that they *'had faith'*. The basis of their 'faith' was often an explicit trust in at least one of the management staff, either the administrator or the DON.

Alternatively, if no trust in the facility management team was present, many SA staff indicated a strong degree of trust in the system, either through increased questioning of the facility's POC or through complaint investigations. The strategy of increased questioning of the facility's POC was believed to signal that the facility *'was on notice'* or that *'the SA was watching them'*, a tactic hoped to promote compliance. In addition, many SA staff considered the number of complaints and/or reportable incidents, against the facility to be a strong indicator of a facility's compliance status to which the SA would respond with a complaint investigation. The effectiveness of such a strategy was not apparent. Three states relegated many complaint investigations to the standard annual re-certification survey, if deemed appropriate following triage for severity. In this scenario complaints could end up being investigated many months after the fact. Besides the obvious disadvantage of this time delay, many complaints may have accumulated adding to the workload of the survey. The following example illustrates such a scenario:

> *'Multiple complaints and incidents, several involving injuries had accumulated for a midsize facility till the time of the standard annual re-certification survey when the actual investigation into each complaint was conducted. All complaints were substantiated, indicating that the incidents occurred, however, none resulted in a citation. During the F tag meeting, the designated complaint nurse reported that she "knew something was wrong, but could not put her finger on it". The subsequent independent study assessment revealed that the facility had many resident-on-resident incidents and falls resulting in injuries and hospitalizations. Due to staff turnover and the thinning of individual charts it was difficult and time consuming to piece the actual circumstances of each case together. Nonetheless, a pattern relating deficient facility practices to resident altercations emerged, many relating to insufficient behavior modification management. The facility failed entirely to maintain behavior logs, therefore, strategies to deal with behaviors were ad hoc and staff was not prepared to anticipate and/or intervene appropriately. Care plans showed these inadequacies clearly; either care plans did not list the behavior problems as a concern and did not specify any interventions, or alternatively, care plans did specify intervention, but the efficacy could never be established. Resident-on-resident behaviors occurred frequently and repeatedly. ' FAC03 SA1*

In general, many SA staff maintained a strong belief that the enforcement system would work either through complaint investigations or through strong facility leadership. However, if the system failed and a facility did not return to compliance as expected, the SA staff were resigned to the belief that those deficiencies would surely be found and cited at the next annual re-certification survey.

3.4.3.2. *Trust, Turnover and Compliance*

Belief in the facility's leadership was not always misplaced, although it is a risky strategy given the high turnover of facility management staff following the survey. The case studies showed many management staff, either the administrator or DON, leaving their position in the first three months following the survey. Surveyors may be astute in assessing the leadership

abilities of a facility's management team during the survey, and, they may even accurately anticipate who may resign, however, no one can be certain of the leadership qualities of the individual(s) replacing a vacated position. The dice may roll either way as the following two case studies illustrate:

'Midsized facility's annual re-certification survey resulted in nine citations including F 309 D for facility failure to appropriately assess, monitor and manage pain. Several management staff, including the DON, resigned their positions following the survey, which prompted corporate headquarters to assign a corporate nurse to assist the facility with its response to the SOD. The corporate nurse was instrumental in writing the POC, which unfortunately addressed only some of the issues indicated on the SOD. Compliance determination was completed by desk review and the facility was cleared on first review, returning its status to substantial compliance. The data collector, having completed an on-site inspection noted that most aspects of the POC had not been implemented. Following several interviews with the Administrator the data collector concluded that the Administrator had no intention to implement any of the POC's corrections, reasoning that that was the responsibility of the new DON. The study followed this facility for two more visits, each one month apart, in order to come to a final conclusion regarding implementation of the POC. Only at the last visit, NH4 conducted four months after the original survey, and two months after the facility had been recertified, the study review assessed the facility to be in full compliance with respect to pain management. The new DON possessed strong leadership and clinical skills. In addition to obtaining the staff's full cooperation to implement the POC, fully understood the original citation, was willing and able to make the necessary improvements so that original citation concerns were addressed and added audits and monitoring of staff to assure long-term compliance. The facility with this DON at the helm stands a good chance to remain in compliance.' FAC94 NH2, 3 and 4.

In this case a newly hired strong and very capable DON instituted the corrective actions as specified in the POC, albeit many months after the facility had been re-certified. This is unfortunately not always the case. In the following example a strong management team hired as 'turn around' team show signs of disintegration at 2nd study visit. In the words of the data collector:

'There were signs that the POC's elements of auditing the direct caregivers was helping part of the time but there are still problems with consistent supervision of caregivers. The fact that the "numbers" have improved (1% acquired pressure ulcers vs. 5 %) does not give the DON reason to believe her root problems are over. She is well aware that they have "a long way to go" in getting the direct care givers to give consistently good care and to genuinely care about the residents. However, she does believe the survey team should take her efforts into account and trust that she will continue to improve. This management team is frustrated and demoralized. They are casting around and looking for reasons and mention that the survey team is "opinionated, can't trust them and biased against them". It hinders them in some ways to really accept the legitimacy of the citations although they seem on the other hand to realize their root problem: inconsistent care by the direct line staff. The DON openly recognizes that many direct caregivers are not motivated. The staff development coordinator recognizes that the nurses don't give direction to the direct caregivers. The supervisor knows she must be "out there watching" and working to get them to give the care she wants them to.' FAC 86 NH2

In this facility the entrenched and long-time direct care staff continued to make it very difficult to accomplish changes as per the POC; no additional changes were made at NH3, one month

later. Management turnover is an unstable transitional period for a facility, accomplishing corrective actions initiated by the enforcement process during that time could be insurmountable.

3.5. Effectiveness Enforcement in Changing Nursing Home Care?

Despite the survey's flaws in detection ability and accuracy and despite lenient enforcement practices at the SA, many nursing homes attempt to be in compliance with regulation either immediately prior to an anticipated survey and/or through the POC immediately following the survey. Study assessments conducted during two on-site inspections to the facility following implementation of the POC, revealed a high rate of only partial implementation of the POC.

In general, tangible problems such as protective covers over heating vents and new pressure relieving mattresses on beds were corrected. In addition, care improvement occurred mostly, but not always for those residents identified in the SOD as recipients of deficient facility practices. However, system changes that would ensure continued compliance for *all* residents were rarely effective, even if the facility made a strong attempt.

Some facilities achieved full compliance at time of SA re-certification, at least in reference to the selected study F tags that had been subject to citation. Some case study facilities continued to improve over time and were in full compliance at the second study revisit (one month after facility re-certification by SA). However, many facilities did not achieve compliance at first or second study visit. Several factors contributing to the success or failure of a facility's full compliance, will be presented here. None can be singled out as the leading cause; in fact both enforcement practices and facility circumstances contributed to either failure or success. Nonetheless, it appeared that facility corrections, if achieved, were more directly a result from identification of deficient practices and the subsequent threat of enforcement actions rather than that enforcement actions per se made the difference.

3.5.1. Enduring Changes: A Major Challenge

Facilities face many challenges at all times and in general these increase during and following the time of survey. Management staff turnover occurred frequently, and this impacted the facility's attempt at correction most often negatively. I n general, strong and stable leadership was necessary for a facility to achieve compliance within the specified time frame following the survey. However the facility's leadership can never accomplish this task by itself; well-motivated, well-trained and caring direct care staff, willing to follow the directions of good leadership, were an additional necessary ingredient to achieve compliance. Multiple factors may contribute to impede compliance; for the case studies denial of the validity or legitimacy of the survey findings; misinterpretation of the SOD; extraneous pressures; and, lack of staff expertise and resources were found contributing factors.

3.5.1.1. 'We Provide Good Care'

Many facilities did make a concerted effort to provide good care; and, many facility staff were committed to the residents and their welfare. The belief that *'care is good here'* was echoed by many nursing home staff at all levels and positions. This belief, which may be valid to some extent, resulted in two distinct reactions from nursing homes. Either the survey findings were invalidated by explaining away some citations; or, more negatively, the SA was accused of *'being inconsistent'*, of *'playing favorites' or* even worse, *' being out to get us'*. These latter two beliefs were ***not*** supported by the study. On the contrary, the study found the surveyors in general to be professional, supportive and more likely to give the facility the benefit of the doubt. Both reactions by nursing home staff, however, prevented the staff from viewing the SOD findings as valid.

Nursing home management staff at times indicated their belief that the citations were minor issues or, *'just documentation issues'*. Occasionally the finger was pointed at one particular staff member as the source of the citation or alternatively at one particular unit or department. These reactions served as impediments to serious reflection on the actual events and often systemic issues that caused the citation. Instead, the citation was often addressed by creating a new piece of paperwork; designing and instituting an in-service to explain the application of the new paperwork protocol; terminating a staff member; and/or replacing a department head. These responses constitute surface changes; systemic change was extremely unlikely to occur when the attitudes described above prevailed.

On many occasions facility management denied the validity of a particular citation, less frequently a facility questioned the legitimacy of the entire process or of the survey team in particular. Lastly the occasional facility demonstrated a blatantly defiant attitude, asserting that only they knew what was best. A defiant attitude in combination with the belief that a citation is unjustified sometimes resulted in 'dodging' or 'fighting the system' rather than focusing on improving the quality of resident care.

3.5.1.2. The Bigger Picture

Some facilities misinterpreted a citation on the Statement of Deficiencies, and at times the SOD provided fertile ground for this. At times, however, a facility, for whatever reason framed a citation according to pre-conceived notions of the issue and failed to recognize the essentials of the citation, as in the following example.

> *'Large, >200-bed, facility incurred 8 clinical citations during the annual re-certification survey including F 314 E for failure to provide basic preventive pressure ulcer care resulting in the development of in-house acquired pressure ulcers. In addition the facility was cited for failure to develop comprehensive nursing care plans under F279 E, all substantiating evidence for this F tag referred back to F 314. Since, on the SOD, F314 was related to F279, facility management staff reframed the issue as a care plan issue rather than a pressure ulcer issue. By correcting the care plans the facility felt it had 'fixed' the problem, entirely missing the essential concerns raised under F314 which referred to basic preventive bedside care such as*

provision of pressure relieving devices, timely repositioning of residents. In fact, one resident's pressure ulcer had not improved since the survey due to the facility's failure to provide pressure relieving devices.' FAC 18 NH3.

Many facilities failed to see the bigger picture presented by a citation and its supporting cases, often resulting in corrections for immediate problems, rather than system changes resulting in sustained compliance. Some facilities emphasized just one or two citations, failing to give other citations equal attention, which then as time moved on, were easily forgotten by direct care staff.

3.5.1.3. 'Life Goes On'

At times a facility was so overwhelmed by extraneous challenges that the entire focus was directed away from the POC and the necessary corrections. When a facility's attention was contracted in such a way, the entire POC was at risk. Staff could only see the latest challenge as apparent in the following illustration.

'Case study FAC13 with 2 citations on the SOD for the annual re-certification survey including, F 316D (inadequate bladder training); and, F371 C (unsanitary kitchen). A desk review of the POC placed the facility back into compliance at first review. The data collector indicated that the facility at time of re-certification had made some corrective changes relative to specific residents, but overall the changes were perfunctory; the underlying issues were not addressed. When visiting the facility one month later, the facility staff was experiencing major upheaval due to a change in ownership. The new owners, a corporation, focused on the census and indeed census had increased by at least 10 new admissions since the latest visit one month prior. Direct care staff felt stressed and overburdened, which was apparent in the daily care; call bells were ringing incessantly as the day progressed. The MDS nurse, responsible for the bladder training program, was asked about continued action as indicated in the POCs she admitted as much as a complete breakdown of the program since new admissions were her current focus. In addition, the new DON, named in the POC as completing audits and observation of the resident as related to their continence, was entirely unaware of her responsibilities. The data collector in asking her questions alerted her to her role as indicated in the POC. This new DON was overwhelmed and very frustrated; even though her former position was as ADON, that position will not be refilled, effectively cutting out an assistant to her new position.' FAC13 NH3

This example shows a facility where ultimately the enforcement process failed for reasons including the extraneous stressors in addition to turnover of facility management staff.

3.5.1.4. Resources and Expertise

In a few facilities either the resources or professional expertise were missing to adequately implement the POC. These facilities were unable to focus on much other than the immediate day-to-day needs and care. At times all hope was pinned on one or two staff members who then were faced with multiple responsibilities and subsequently could not meet the unrealistic expectations. In the following case the data collector provides a rather grim picture of the way a nursing home is coping with its day-to-day problems, negatively impacting the implementation of the corrective actions indicated on the POC:

'On this third visit to the nursing home, my conclusions with respect to correcting several of the many citations remained largely the same. There were half-hearted attempts to use new lab monitoring tools, new infection control processes and the MDS were somewhat better but still behind. What was shocking to me was the fact that the so-called "QA nurse" has not been going to the QA meetings. She is mentioned repeatedly in the POC as being the person who is going to monitor that the improvements are in place. The QA nurse is a rather timid individual who admits to giving the unit managers and charge nurses suggestions, which they do not receive well from her. She appears to have to get her authority by directing it through the DON. Additionally the QA nurse is totally overwhelmed by her role as MDS nurse. Last month she took a week off and went to a large city in a neighboring state to take an MDS course, which she paid for herself. She believes she learned enough to help improve the RUG scores for reimbursement. Her work process is impeded because she must share the computer with the other members of the interdisciplinary team. She also has to cover weekends as supervisor twice a month. She admits that many times instead of using some of her time doing MDS she ends up working as a staff nurse because of "call-ins". When I questioned her about her MDS process, she commented that she left it up to the charge nurses and unit managers to create the care plans. She tries to instruct them to correspond the care plans to the RAPs but they don't always do that. Many of the nurses are LPNs who have worked here 20-30 years and who have few skills with the assessment process. FAC04, NH3

At times it was the direct care staff that made implementation of the corrective actions all but impossible; resisting and obstructing every possible change and blocking any avenue for improvement. Even strong leadership will ultimately succumb to such a situation and in general implementation of the POC failed.

3.5.2. Obstacles in the Regulatory Process

The enforcement process takes place between two major players and each of their actions calls forth a reaction from the opposite player. This section will review some of the responses that the enforcement actions may provoke as evident from the case studies. In conducting these case studies it became apparent that one of the most important objectives of the regulatory process in nursing facilities, which ultimately is provision of resident care at an acceptable professional standard, was lost.

3.5.2.1. SOD, Who Does It Serve?

Citations were listed under the regulatory F tag that closely described the deficient facility practice. However, a regulation often incorporated many different aspects under one F tag; i.e. F 314 refers to the failure of the facility to *prevent* the development of new pressure ulcers ***and/or*** the failure to adequately and/or timely *treat* a pressure ulcer. Usually only one or a few aspects are represented in the cited deficiency. Although the F tag is not ambiguous, the citation may refer to either the prevention or treatment of pressure ulcers and, in addition, may refer to one particular aspect of prevention *(inadequate assessment)* or treatment *(failure to document consistently)*. Specifics were often relayed in the substantiating evidence and this at times resulted in misinterpretations. In the following case, tying two F tags together allowed

one nursing home to reframe the issue, while entirely missing the essential problem provided under one of the F tags.

Facilities at times misinterpreted what was cited. The substantiating evidence provided with each F tag did specify, often in great detail, which practices resulted in the citation. However, the minutiae provided, referring to each involved resident (by survey ID); specific staff; date, time, and type of data collection; and, the specifics that were spoken or observed, were at times so overwhelming that a reader may have great difficulty determining what exactly was the issue. On many occasions SA staff told the data collectors that the SOD is written with the Informal Dispute Resolution in mind; SA-staff, in writing the SOD, placed all 'its ducks in a row'. This tactic may serve well in case of an IDR, in fact the SA reportedly lost very few IDR disputes; it does not improve the clarity of the document, a complaint heard from many facility staff. One data collector minced no words: 'nursing facility personnel do **NOT** understand the legalese in the SOD.

SA staff used similar reasoning to explain the actions of downgrading and removal of an F tag. Downgrading and removal of F tags because of *'insufficient evidence to hold up in IDR'* really only served the enforcement process rather than the residents whose interests it purportedly had in mind. Downgrading and removal of F tags invalidated survey findings, which then in turn supported the already existing attitude of denial that substandard care may exist. Since the study assessment supported, in all cases of downgrading, the original citation (pertaining to the study F tag) it must be concluded that this may have an unintended effect on the facility's quality improvement. The nursing home had no reason to believe that substandard care may be a problem, therefore no corrections will be made. This was a serious, undoubtedly unintentional, side effect of these actions.

3.5.2.2. *Enforcement Process*

The enforcement process was experienced by almost all facility management staff as punitive and unrelenting. Even though the enforcement actions executed against the case study facilities hardly supported this perception, it existed nonetheless. The fact that many management staff resigned or was terminated within a couple of months following the survey, although not necessarily attributable to the survey, was rather disheartening.

This turnover was often portrayed by interviewed respondents as having little or nothing to do with the survey. Nonetheless, interviews with the resigning person often revealed a feeling of defeat, one had worked so hard and there was so little to show for it. These feelings of defeat indicate a basic flaw in any type of audit where the focus is exclusively on the negative, i.e. deficient care. Some survey teams tried to compensate for this negativity during the exit conference and attempted to stress some of the good things they had seen in the facility. Yet the SOD does not make mention of what might have been accomplished, and the survey results does not give the nursing home an actual sense of its comparative ranking among its peers and in its own deficiency history. Surveyors were keenly aware of where a facility ranked and how

it had progressed with its quality of care history. Surveyors, when asked, have no compunction in rating a facility.

This unintended effect of the survey has considerable implications for the subsequent process of quality improvement in the nursing home. Management staff were most instrumental in accomplishing relevant changes in the facility following a survey; they knew the facility and its problems intimately and thus could assist in establishing improvement most appropriate to the particular situation and with the best potential to reach the bedside. These improvements were now postponed and in some cases did not happen at all.

The case studies revealed that enforcement actions were rarely executed, and if administered consisted of monetary penalties either in the form of CMPs or DPNA. Even though many SA staff strongly believed in penalties as an effective tool to enforce compliance this was certainly not confirmed by the case studies. Nursing homes face many different challenges and a one – size enforcement action (monetary penalties) may not fit all. Even though the penalties were rarely exorbitant, it may exacerbate some of the already existing problems. SA staff often indicated that alternative enforcement options such as Directed Plan of Care or Facility Monitoring were too time-consuming or too involved for the SA. Still, the varied options for enforcement were certainly underutilized. Because they were underutilized, we have no way of estimating how effective they may or may not have been.

4. DISCUSSION

Given the limited rate of detection of care deficiencies, poor identification of specific care issues and under citation of these findings, the on-site survey was again found lacking. Despite good intentions, the surveyors proved unable to appropriately choose areas for focus and failed to identify some of the most blatant care problems. The survey, as presently designed and implemented, requires heavy investment of time and resources to detect deficient care. At the same time, the heavy emphasis on procedural exactitude often prevents surveyors from pursuing full investigation of deficient care that is of real importance, such as G-level citations.

The case studies revealed that enforcement actions, if executed, have only a limited positive effect. Some nursing homes responded well to the identification of deficient practices and made improvements accordingly. However, it must be recognized that nursing home behavior changes seldom occurred without a formal citation. Further, some nursing homes responded to the detection of deficient practices and the issuance of a formal citation with denial and/or indignation and made only perfunctory gestures that resulted in minor changes or no change whatsoever.

Variation in nursing home responses had little apparent relationship to the enforcement process, be it detection, citation and/or enforcement actions. The most consistent factors associated with changes (in accordance with regulations) were the willingness and ability of management staff to enact change and, to a lesser degree, willingness of direct care staff to

accept the survey's verdict and respond accordingly. The enforcement process unwittingly and unintentionally undermined its own authority by downgrading and removing preliminary survey findings, effectively decreasing the legitimacy of the survey and the Statement of Deficiency.

Facility leadership and the willingness to accept the survey verdict as legitimate was but one factor influencing nursing home behavior changes in accordance with regulatory mandates. Equally important were the presence of the expertise and resources necessary to implement the required changes. It is at this level that the regulatory process can play an important role in encouraging nursing home behavior changes in the direction of compliance by selecting enforcement actions that assist a facility rather than hinder it. The case studies revealed that enforcement was determined according to CMS mandated actions, but the alternate options (which could be tailored to meet a facility's specific problems and needs) were not used. This self-imposed limitation may be understandable in light of the regulatory agency's own limited resources, but it ultimately does little to benefit the goal of sustained and enduring compliance. The fact that many citations were repeated year after year indicated that many facilities do not establish enduring compliance and suggest an ineffective regulatory system.

Enforcement in response to the survey is anticlimactic and almost nonexistent. If enforcement occurred, it was generally monetary in nature and was not determined on a facility-by-facility basis. Enforcement actions were selected by rote, with little imagination or differentiation between the needs or problems of facilities. When employed in this manner, enforcement sanctions do not make use of their full potential and prove relatively ineffectual. Further, the perfunctory re-visit does not do justice to the substantial effort of the survey, nor does it support the nursing home in quality improvement. While the case study facilities subjected to these sanctions may have increased their efforts to come into compliance, they did not show improved quality of care and/or a higher rate of sustained compliance. This finding suggests that the current enforcement actions can be interpreted as temporary and minimally effective with respect to the goal of effecting sustained improvement in the quality of care. Admittedly, the facilities' inability to remain in sustained compliance is the result of a variety of factors, many of which are entirely extraneous to the enforcement process. However, it is within the capacity of CMS and the state agencies to adjust their practices to improve quality of care for the nursing home residents protected by the federal regulations.

The primary failing in the current implementation of enforcement sanctions lies in an inherent contradiction between the facility-level focus of the survey process and the generic, one-size-fits-all approach of the enforcement process. Further, the enforcement process is stymied by an unresolved tension between competing roles: is enforcement a legalistic regulatory process or is it to be conceptualized and operationalized as a collaborative quality improvement process? The current approach takes a middle ground that accomplishes neither set of objectives.

While CMS clearly states that the role of the surveyor is that of determining compliance to standards and that is the only appropriate role,[5] states and survey teams may elect a different

interpretation. State surveyors bring their backgrounds and training with them when they become surveyors. Some surveyors may come from a regulatory perspective and act in accordance. Other surveyors are hired with prior experience working in nursing home settings. These individuals may have empathy with the nursing home sites and want to help them or educate them. This desire may lead them to view and perform their roles as more than just regulators. As further inquiry is made into the survey and enforcement process, it will be important to recognize that there may exist a continuum of belief systems and approaches being employed by surveyors, whether implicit or explicit.

The case study findings corroborate and augment prior work by providing an in-depth view of participants' perspectives and attitudes towards the survey and enforcement process. Respondents were candid in sharing their thoughts with the UCHSC research team. Both the nursing homes and the state agencies seemed to welcome the opportunity to express their perspective, revealing some of the problems and pitfalls they encounter. The case studies provided a clear opportunity to uncover what affected the interplay between the two involved institutions and how this dance affected the quality of care in nursing homes.

5. CONCLUSIONS AND IMPLICATIONS

It would be easy to infer from this study that the current regulatory enforcement process is a failure. But that interpretation would overlook some very important positive findings and qualifications:

- Survey-identified deficiencies were real problems and confirmed independently by the data collectors – i.e., there were essentially no false positives;
- The often heard accusation that the surveyors we "out to get" the providers was not supported by the data collectors' observations. The surveyors acted fairly and professionally;
- Although "the case studies revealed that enforcement actions, if executed, have only a limited positive effect . . . it must be recognized that nursing home behavior changes seldom occurred without a formal citation";
- The State Agency survey staff were doing the best they could with the tools and resources (staff, budget) available and some of the choices they made – e.g., desk review vs. on-site follow-up review, or downgrading to avoid having to do follow-up) - were at least reportedly driven by lack of resources to do appropriate follow-up;
- G or higher level citations consistently led to similar enforcement actions, suggesting at this higher level of harm there was consistency in enforcement action.[2]

[2] Also, it should be noted that subsequent to the data collection for this study, CMS established a joint State-Federal workgroup to develop an analytic tool that will assist in assessing whether States are imposing Civil Money Penalties (CMPs) consistently. Pilot test of the tool has been conducted and the preliminary findings are positive.

It is also important to be mindful of the problems and limitations of all enforcement systems, including the criminal justice system, meat and poultry inspection, and environmental health and safety.[3]

The findings suggest that despite its many and sometimes serious failures, the regulatory enforcement process in nursing facilities has the potential to play a major role in determining the quality of care in nursing homes. Nursing facilities prepare in anticipation for an upcoming annual re-certification survey, attempting to comply with as many regulatory statutes as possible. This anticipatory attitude on the part of the nursing facilities encourages compliance with minimum regulatory standards, ultimately affecting the quality of care.

Nursing facilities are mandated to make changes in response to a survey if deficiencies are established and citations are issued, resulting in enhanced quality of care for the facility and for residents. However, it is also at this level that the enforcement process shows its greatest weaknesses: impaired detection ability, a tendency to minimize deficient practices, and a perfunctory process of compliance approval. Compounding (or perhaps driving) these problems is the legalistic frame of mind (fear of IDR) at the supervising Survey Agency level. This approach undermines the legitimacy of survey findings, undermines the authority of the surveyors, and ultimately fails to assure quality improvement for residents. Finally, many nursing facilities experience the enforcement process as punitive and unrelenting and would prefer a more consultative approach.

The case studies demonstrate that there is a great deal of subjectivity throughout the current survey process including: care problem identification, the decision to cite, the F tag to cite, scope and severity, what to document, the revisit process, and ultimately enforcement action decisions. This subjectivity makes the surveyor's job stressful and time consuming as they try to make the "right" decisions and generate the supporting documentation. This subjectivity leaves the nursing home constantly questioning citations, and, consequently, they invest less in responding to the survey findings.

Fortunately, CMS realizes that this is the root of the problem. With the Quality Indicator Survey (QIS), they are testing a more objective process for problem identification, investigation leading to citation decisions, identification of appropriate F tags, documenting findings throughout the process, and revisits. By virtue of this objective information, the QIS forces greater clarity relating to scope and severity. Anecdotal results from the demonstration suggest that both surveyors and nursing home staff find the QIS process more objective and consistent. Surveyors appear to be more confident with their citations and fewer citations are both challenged through and reversed in IDR.

---

[3] It is interesting to note the problems with coal mine safety inspection that became public after the data collection for this study was concluded. See "Senators say mine safety agency needs more money." GOVEXEC.COM, *http://www.govexec.com/dailyfed/0106/012306cdpm1.htm*, January 23, 2006.

Moving toward a quantitative and structured quality assurance process on the survey side could result in quality systems for nursing homes that would help them respond to citations with quality improvement, and ultimately, provide higher quality care throughout the year.

Reference List

(1) American Health Care Association. Facts and trends: the nursing facility sourcebook 2001. 2001. Washington, DC, American Health Care Association.

(2) Institute of Medicine. Improving the Quality of Care in Nursing Homes. 1986. Washington, National Academy Press.

(3) Kramer AM, Grigsby J, Cooper D. Analysis of the Validity of Quality of Care Determinations. Chapter 4 in Evaluation of the Long-Term Care Survey Process. 1996. Bethesda, Maryland, Abt Associates.

(4) United States General Accounting Office. California nursing homes: care problems persist despite federal and state oversight. Report to the Special Committee on Aging, U.S. Senate. GAO/HEHS-98-202. 1998. Washington, D.C., United States General Accounting Office.

(5) Health Care Financing Administration. Report to Congress: Study of Private Accreditation (Deeming of Nursing Homes, Regulatory Incentives and Non-Regulatory Initiatives, and Effectiveness of the Survey and Certification System). Volumes 1-4. 1998. Baltimore, MD.

(6) Office of Inspector General. State Referral of Nursing Home Cases. OEI-06-03-00400. 2005. Washington DC, Department of Health and Human Services.

(7) Office of Inspector General. Nursing Home Enforcement: Application of Mandatory Remedies. OIG-06-03-00410. 2006. Washington DC, Department of Health and Human Services.

(8) United States General Accounting Office. Nursing Homes: Despite Increased Oversight, Challenges Remain in Ensuring High-Quality Care and Resident Safety. GAO-06-117. 2005. Washington DC, United States General Accounting Office.

(9) Kramer AM, Hrincevich CA, Pool JS, Cooper D, Carter D. Pilot Test of a Staged Quality of Care Survey Using Quality Indicator Profiles. 1994. Denver, CO, Center for Health Policy Research.

(10) Kramer AM, Zimmerman D. Evaluating the Use of Quality Indicators in the Long-Term Care Survey Process: Final Report. 2005. RTI International.

(11) Centers for Medicare & Medicaid Services, UCDHSC Division of Health Sciences Center CMS Quality Indicator Survey Demonstration Project Brochure. 2007.

(12) Harrington C, Carrillo H. The regulation and enforcement of federal nursing home standards, 1991-1997. Medical Care Research and Review 1999; 56(4):471-494.

(13) Centers for Medicare & Medicaid Services. Nursing Home Data Compendium. Centers for Medicare & Medicaid Services. 2006.

(14) United States General Accounting Office. Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards. GAO/HEHS-99-46. 1999. Washington DC, United States General Accounting Office.

(15) United States General Accounting Office. Nursing Homes: Sustained Efforts are Essential to Realize the Potential of Quality Initiatives. GAO/HEHS-00-197. 2000. Washington DC, United States General Accounting Office.

(16) Committee of Improving Quality in Long-Term Care, UCDHSC Division of Health Care Policy and Research, Institute of Medicine. Improving the quality of care of long-term care. Wunderlich GS, Kohler PO, editors. 2000. Washington, D.C., National Academy Press.

(17) Morgan D. Practical strategies for combining qualitative and quantitative methods: applications to health research. Qual Health Res 1998; 8(3):362-376.

(18) UCDHSC Division of Health Care Policy and Research, Centers for Medicare & Medicaid Services. Quality Indicator Survey (QIS) Surveyor Resource Manual. Denver, CO: University of Colorado at Denver and Health Sciences Center, 2006.

CR INVESTIGATES

Nursing homes
Business as usual

Two decades after the passage of a federal law to clean up the nation's nursing homes, bad care persists and good homes are still hard to find.

In 1987, Congress passed a landmark law meant to improve nursing home care for the elderly. But our investigation reveals that poor care is still all too common, especially at nursing homes run by for-profit chains, now the dominant force in the industry.

CONSUMER REPORTS' analysis found that not-for-profit homes generally provide better care than for-profit homes, and that independently run nursing homes appear to provide better care than those that are owned by chains. In a separate study, we found that many states are lax in penalizing bad homes.

For this report, we analyzed the three most recent state inspection reports for some 16,000 nursing homes across the U.S. We also examined staffing levels and so-called quality indicators, such as how many residents develop pressure sores when they have no risk factors for them.

The Consumer Reports Nursing Home Quality Monitor, formerly the Nursing Home Watch List, is available free at *www.ConsumerReports.org/nursinghomes*. It lists facilities in each state that rank in the best or worst 10 percent on at least two of our three dimensions of quality. By examining the kinds of homes that tend to cluster at either end of the continuum, we can make some judgments about how likely a facility is to provide proper care.

This year's list, financed by a grant from the Commonwealth Fund, a philanthropic organization, is the fifth we've published since 2000. We've seen little evidence that the quality of care has improved since then. Indeed, 186 of the homes cited for poor care on this list have also appeared on earlier lists of poor-quality homes.

Consider the White Blossom Care Center, part of a for-profit chain in San Jose, Calif. From the outside, it looks like many of the nursing homes that dot the California landscape: wings of residents' rooms and a parking lot full of cars. Inside we saw nothing that would arouse unease. Residents nodded off in wheelchairs, and aides chatted at nurses' stations as an occasional visitor walked through the halls.

White Blossom, though, is no ordinary nursing home. It's one of 12 that have been on each of our lists of poorly performing homes since 2000. Its state inspection, conducted last August and current when our reporter visited in December, raised troubling questions about the care it delivers.

Page after page of the unusually long document detailed failures to follow doctors' orders, perform a pain assessment, monitor pressure sores, screen for tuberculosis, or properly sanitize dishes and utensils. The 43-page report told of a stroke victim with swallowing problems who was left unsupervised with mushy material in her mouth. And it mentioned a medication error that could have been fatal. The survey also reported on the facility's plans to correct the deficiencies that were cited.

The survey, which by federal law must be "readily accessible" in every nursing home, was not visible in the lobby when our reporter arrived. Only after she insisted on seeing it did the home's administrator produce it. A staff member at the front desk said the report wasn't initially available because it was being used by someone else at the time. Steven Earle, White Blossom's administrator, wouldn't comment on specific deficiencies but said that they had been corrected.

During the three-year period we studied, 657 homes across the country were cited for failing to make their inspection results readily accessible.

CR Quick Take

Our investigation found that the state agencies responsible for overseeing nursing home care have often failed to correct problems. But consumers can increase their odds of choosing a good nursing home if they narrow their search to certain types. Our findings:

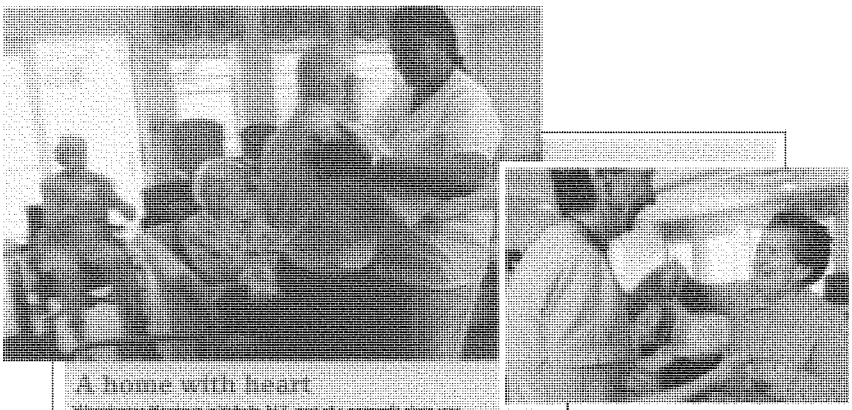
- **Not-for-profit homes are more likely to provide good care than for-profits, based on our analysis of inspection surveys, staffing, and quality indicators.**
- **The same analysis shows that independently run homes are more likely to provide good care than chains.**
- **Through its influence in politics, the industry has whittled down the protections of the 1987 federal law.**

SKIMPING ON CARE?

While our investigation suggests that you or a family member might receive better care at a not-for-profit, independently owned facility, they make up a small portion of the industry. Since the establishment of Medicaid, the state and federal program for the poor and the elderly, in the 1960s, for-profit homes have come to dominate the field.

"In some chains we see facilities that will consistently do poorly," says Paul Dreyer, director of licensing and certification in the Massachusetts Department of Public Health. "Sometimes it hasn't been the chain's priority to make facilities the best they can be. The focus is maximizing some kind of return to investors."

Bruce Yarwood, president and CEO of the American Health Care Association



A home with heart

Westminster Manor in Toledo, Ohio, part of a nonprofit chain, was among the homes in the top 10 percent on our nursing home quality monitor list.

PHOTOGRAPHY BY ANDREA FISCHMAN

(AHCA), which represents primarily for-profit homes, says that poor homes are a "chronic, tough issue." He notes that many nursing home executives have trouble escaping Wall Street's quarterly earnings pressure. But, he says, "For every bad story there are probably 50 good ones."

Nursing home researchers say that the most serious problems sometimes show up in small, for-profit chains within a state. In New York, for example, Healthcare Associates, wholly owned by Anthony Salerno, jointly administers a network of 12 separately incorporated facilities. Salerno is the largest shareholder in all the facilities. Three of the homes have been on our quality-monitor list.

Earlier this year Eliot Spitzer, New York's attorney general, sued one of the three homes, the Jennifer Matthew Nursing and Rehabilitation Center in Rochester, alleging abuse and neglect. Investigators used a hidden camera to show that call bells were placed out of residents' reach and that patients would go unturned and unwashed for hours. That facility was a four-time repeater on our lists. The legal case is ongoing; a lawyer for the center did not respond to requests for comment.

One reason the independently owned, not-for-profit facilities might do a better job is that they tend to have more staff, which experts agree is crucial to good care. We found that on average, not-for-profits provided almost an hour of additional nursing care each day per resident, compared with for-profit facilities. They also provided nearly twice as much care from registered nurses.

In 2002, a study conducted for the federal Centers for Medicare & Medicaid Services (CMS) noted that without a daily average of 2.8 hours of care from nurse aides and 1.3 hours from licensed nurses, residents were more likely to experience poor outcomes — pressure sores and urinary incontinence, for example. "Most nursing homes are staffed significantly below that," says John Schnelle, director of the Borun Center, a joint venture of UCLA and the Jewish Home for Aging that does research on long-term care.

The CMS, however, has not recommended or adopted minimum staffing standards, a point of contention for nursing home advocates, who are pushing for them. Marvin Feuerberg, a technical director at the CMS, says officials even watered down the 2002 study's executive summary when it was given to Congress.

Instead, current rules say that staffing must be sufficient to meet the needs of nursing home residents, a standard so vague that it makes penalizing nursing homes that skimp on care almost impossible. Rules do require homes to have 8 hours of registered nursing and 24 hours of licensed nursing coverage per day. But the standard applies to all homes, no matter how many residents they have. So a nursing home with 200 residents can use the same-size staff as one with 20.

Inadequate staffing puts residents at risk. Glen Barnhill, 46, of Nashville, lived in Tennessee nursing homes for several years after he suffered a gunshot wound to the head. Barnhill, a quadriplegic who needs a ventilator to breathe, says he would sometimes go into respiratory distress while waiting for a call light to be answered. "I'd be in bed gasping and fighting for air, not knowing when the nurse would come," he says.

The AHCA says that minimum staffing rules cannot be an unfunded mandate on the part of the government. "If you're required to have x amount and certain types of staff, you need reimbursement," says Sandra Fitzler, the group's senior director of clinical operations. More money from Medicaid, which pays for more than half of all nursing home stays, would improve staffing, the industry says.

But money is not always the problem. We examined Medicaid reimbursement for nursing homes in 2002, the last year for which we had complete data. We found no evidence that the average state Medicaid payment to nursing homes had a significant impact on the percentage of homes identified as poor performers.

PLAYING POLITICS

Nursing homes are not major donors to national political campaigns, but they wield considerable clout in state capitals, where their $500, $1,000, and $3,000 contributions count with gubernatorial, state legislative, and judicial candidates.

In Arkansas, for example, the industry was a top contributor to state candidates in 2004, according to Followthemoney.org, a nonpartisan database of campaign con-

tributions. The Arkansas Health Care Association, which represents for-profit nursing homes, gave almost $100,000 that year to candidates in the state.

The trade association also maintains an office near the Arkansas Capitol in Little Rock, where legislators can stop in and enjoy a free lunch three times a week during legislative sessions.

"They contribute a large amount of money to people's campaigns" and the politicians become beholden, says state Sen. Mary Anne Salmon, a Democrat. She adds, "Nursing homes have stopped some very good legislation that would have made things better for the elderly."

Messages from legislators, subtle and not so subtle, filter down to regulators, who have learned that nursing homes will challenge them if they press too hard. Grachia Freeman, a former nursing home inspector in Arkansas, says that supervisors "would not let me write deficiencies I wanted to write" for a facility she was inspecting. Now a nurse at a VA hospital in North Little Rock, she adds, "They were angry with me for investigating and told me not to complete the survey." We made several efforts to interview regulators in the long-term-care unit of the Arkansas Department of Health and Human Services but were repeatedly rebuffed.

This pressure "gives facilities the confidence to push back in so many ways, like appealing citations and sanctions because they know that state legislators tend to be very protective of homes in their districts," says Iris Freeman, principal consultant with Advocacy Strategy, a Minneapolis firm that works with community groups on behalf of the elderly and disabled.

EASING OFF OF ENFORCEMENT

Although the number of deficiency citations written by state inspectors has increased 7.6 percent since 2003, according to the CMS, inspectors appear to be watering them down. Each one carries a letter code, from A through L, indicating the scope and severity of the violation. Citations labeled G through L denote actual harm or the potential for death. Codes I through L indicate that the harm was widespread, affecting many people.

State inspectors are now writing fewer deficiencies with codes that denote actual harm, such as avoidable pressure sores

shopsmart

HOW YOU CAN FIND GOOD NURSING HOME CARE

Choosing a humane, well-run nursing home can be one of the most important decisions you'll make in life. Unfortunately, it can also be one of the most rushed. Even when good information is available, you may have little time to digest it, especially if a hospital discharge planner says your relative must be out in 24 hours. He or she will often suggest a particular nursing home in the area, but you may not know whether the home is your best choice or a very bad one.

If you find yourself in this situation, first know that you can use your appeal rights under Medicare to extend the hospital stay for two days. That will buy you additional time. Then follow these steps:

Get the names of local facilities. The Eldercare Locator (800-677-1116) will refer you to your local agency on aging. It, in turn, can supply you with a list of nursing homes and contact information for the local ombudsman, a government official whose job is to investigate nursing home complaints and advocate for residents and their families.

Consult our online Quality Monitor *(www.ConsumerReports.org/nursinghomes)*. It will help you cross potentially bad homes off your list. Avoid facilities that have appeared on our list repeatedly and those that performed poorly on two of our three dimensions of quality. If a nursing home near you is on our "good" list, put it on your list of possibilities. Also check state penalty information on our site. If a nursing home has received a state fine, even a small one, consider that a warning.

Check the ownership. A resident's chances of receiving good care are better at an independent not-for-profit facility than at a for-profit chain. You should ask whether the facility is about to (or has) changed owners. One that's on the auction block might have problems, just as one with a new owner might be getting better. Be aware that if the facility is part of a large corporation that has split itself into smaller, limited-liability companies, you may have little recourse against the home if things go badly for your family member.

Check with the local ombudsman. He or she should be able to tell you about homes in your area. We say "should" because many ombudsmen have encountered pressure from the industry and are now very careful about what they say. Comments such as "You may want to look further" or an unenthusiastic "They're OK" could be warning signals.

Don't depend on the federal Web site. The Centers for Medicare & Medicaid Services maintains a Nursing Home Compare site at *www.medicare.gov*. But our comparison of the information on that site and the state inspection reports on which it is based show that you'll probably get an incomplete and possibly misleading picture of any home that you have under consideration.

Visit the homes. Once you've narrowed your search, make unannounced visits. Connie Smith of Little Rock, Ark., pictured at right, visited five homes, several repeatedly, before selecting the Greenhurst Nursing Center in Charleston, Ark., for her son Jordan, 23, who as a child became a quadriplegic due to a BB gun accident. She's pleased with the personal attention he has received. When Jordan turned 21, the nursing home administrator put a drop of beer on his lips to mark his coming of age.

Read each home's Form 2567. That is the facility's state inspection survey, which should be "readily accessible." If it's not and you have difficulty obtaining it, consider that a warning that the facility may be hiding damaging information. A lengthy survey with lots of violations indicates problems. The administrator might tell you they've been fixed, which may or may not be true. But even a deficiency-free survey is no guarantee of good care. It may merely mean that the inspectors were not looking very hard.

Visit the homes again. Drop in between 9:30 and 10 a.m., for example, to see how many people are still in bed. Homes with too few staff members don't get people out of bed until late in the day, if at all. Also visit at dinnertime. If 75 percent of the residents are eating in their rooms, that's not a good sign. Most people prefer to be out of bed and to eat in

The right match

Jordan Smith, 23, lives at the Greenhurst Nursing Center in Charleston, Ark. His mom, Connie Smith, says, "There is something that works here."

and medication errors. "We are going back to a less stringent and simpler enforcement," says a federal analyst familiar with nursing home inspection data at the CMS. "Everything is becoming a D level. Nursing facilities are going to challenge anything above a D level if it carries a mandatory penalty, can be used in a tort case, or will be publicly disclosed."

In 2000, 40 percent of all deficiencies carried a D designation. By 2005, the number had risen to 54 percent. The reason, says the analyst, is pressure from nursing homes on understaffed state agencies that find it hard to muster the resources to defend their citations in court.

The most common remedy for violations is a "plan of correction." The nursing home acknowledges there is a problem and promises to fix it within a specified period. Often the problem is corrected but soon resurfaces, a phenomenon regulators call yo-yo compliance.

PHOTOGRAPHY BY WESLEY HITT

the dining room. Ask the nurse aides how many residents they each care for. The smaller the number, the better.

Ask about top-level turnover. If the administrator and the director of nursing have worked at a facility for several years, that's a positive sign. Frequent changes in those positions indicate instability, which could translate into poor care.

Talk to the administrator. Try to get a sense of his or her philosophy of care and how well it's communicated to staff members. Good care begins with the facility's leadership.

TOKEN FINES OR NONE AT ALL

The 1987 nursing home reform law provided for monetary penalties that could be imposed by states and the federal government. But that hasn't meant that fines are collected. In fact, last year the federal Office of the Inspector General found that the CMS did not take all the required steps to collect 94 percent of past-due penalties.

Some states are doing no better. Even when inspectors find that homes are providing poor care, regulators may be slow to impose fines, if they levy them at all.

In 2003 and 2005, CONSUMER REPORTS examined whether states were levying fines against our sample of poorly performing homes. We found that the ones that could impose fines were not always using that authority. Our earlier study found that in states with the power to impose fines, only 55 percent of the facilities in our sample that could have received one actually did. In our most recent analysis, we found that states fined just 50 percent of such homes.

Eight of the 12 five-time repeaters on this year's list of poorly performing homes had not received state fines between 1999 and 2004. The others received minimal penalties. California regulators, for instance, fined White Blossom a total of $10,800 during the six years it was on our lists. The largest fine it received in any one year was $3,600.

When fines are assessed, they tend to be low, sometimes absurdly so. Consider the slap on the wrist given the Willow Tree Nursing Center in Oakland, Calif. In 2001, according to state records, a 38-year-old paraplegic with poor cognitive ability left the home on a pass. When he did not return until 2 a.m., the home's administrator ordered a nurse not to let him back in. Regulators cited the facility for failing to keep a resident free from mental abuse and assessed a fine of $700. The state, however, collected only $455 and closed the case. Seventeen months later, the state again cited Willow Tree, for failing to report an allegation of abuse within 24 hours. This time, a nurse allegedly put a pillow over a resident's face; said, "I'm going to smother you"; and then walked out of the room laughing after the patient pushed it off. The state collected $600.

States can reduce an already meager fine by 35 percent if the nursing home agrees not to appeal. The median fine in 1999 for the homes we looked at was $4,800; in 2004 it had dropped to $3,000. Less than 2 percent of the homes received a fine greater than $100,000.

"The system hasn't been hard enough on those who view penalties as the cost of doing business," says David Hoffman, a former federal prosecutor in Philadelphia who has sued many nursing homes and now consults with the industry about improving the quality of its care.

SHUTTING DOWN A HOME

The CMS can disqualify a home from the Medicare and Medicaid programs, cutting off federal funds. But that remedy, the most drastic in the agency's arsenal, is used less frequently than in the past. In 1998, the number of terminations peaked at 51; in 2005 there were only 8.

States can also try to shut down what they judge to be poorly performing facilities. In 2005, Indiana regulators investigated a complaint that a student nurse aide at the Hanover Nursing Center in Hanover had beaten a resident in the face, an immediate-jeopardy violation. That inspection resulted in a 62-page report detailing numerous violations.

Regulators placed a 45-day ban on admitting new residents to the home but lifted it after further inspection. In February, Hanover's license expired, and state officials refused to grant a new one. The facility is appealing the loss of its license and a federal fine of $117,500 for the immediate-jeopardy violation. Meanwhile, it continues to operate.

For more information

Free: The Consumer Reports Nursing Home Quality Monitor, which lists homes to consider and those to avoid based on our analysis, will be available Aug. 7 at *www.ConsumerReports.org/nursinghomes*. You'll also find other help with choosing a home.

Faces of Neglect

By the time Ralph B. was treated for dehydration, it was too late. The severe dehydration and high sodium levels Mr. B experienced had created such an imbalance in Mr. B's electrolytes that his brain was poisoned.

Mr. B was not able to recover. He was placed in hospice care and was unconscious most of the next month. However, shortly before his death, he opened his eyes and began talking to his relatives. He spoke his last words to his six-year-old granddaughter, to whom he said, *"Don't forget me."*

The Faces *of* Neglect

Behind the Closed Doors of Nursing Homes

National Citizens' Coalition for Nursing Home Reform
1828 L Street, NW, Suite 801
Washington, DC 20036
Phone: 202-332-2275
http://nursinghomeaction.org

Acknowledgements

We wish to pay tribute to the residents whose stories are told in this book. These women and men endured suffering that could have been avoided, and, in many cases, they died needlessly. Those of us who researched and chronicled their experiences found it almost impossible to imagine their pain. We hope that the telling of their stories will help prevent similar agony for current and future residents of long-term care facilities.

We are also deeply grateful to the family members of these residents who were willing to share their stories with the public despite the painful memories. Families told us that they pursued litigation because they wanted poor care in long-term care facilities to be addressed and did not want any other resident to be subjected to the terrible suffering that their loved one experienced.

Finally, we wish to thank the attorneys who litigated these cases and who provided us with the information used in the publication of this book, and the members of NCCNHR's Faces of Neglect advisory committee—Norma Harrison Atteberry, RN, Advocates Committed to Improving Our Nursing Homes; Alison Hirschel, Esq., Michigan Campaign for Quality Care; Steven Kilpatrick, Esq., Connecticut Citizens' Coalition for Nursing Home Reform; Debbie McCabe, Texas Advocates for Nursing Home Residents; and Kevin McLean, Esq., Fighting Elder Abuse Together (FEAT) — whose professional insight and advice were invaluable.

For 30 years the National Citizens' Coalition for Nursing Home Reform (NCCNHR) has worked to protect the rights, safety and dignity of America's long-term care residents. Founded in 1975 by Elma Holder and located in Washington, DC, NCCNHR's mission is to accomplish quality through:

- Informed, empowered consumers
- Effective citizen groups and ombudsman programs
- Promoting best practices in care delivery
- Public policy that is responsive to consumer needs and
- Enforcement of standards.

NCCNHR's members include long-term care residents, their family members and friends, long-term care ombudsmen, state and local citizen advocacy groups, and professionals in the long-term care field who seek to protect residents' rights and improve care in nursing and assisted living facilities. NCCNHR's primary work is related to consumer education, empowerment of resident advocates, family council development, strengthening state and local long-term care ombudsman programs, and public policy advocacy. The organization is a leading national voice for the need to raise nurse staffing levels and fully implement the 1987 Nursing Home Reform Act so that residents receive the individualized, person directed care that they need and deserve. NCCNHR also promotes quality of care and quality of life in board and care homes as well as assisted living facilities.

Because the right of residents to bring civil lawsuits is crucial, both to redress the wrongs committed against them and to deter neglect and abuse of others, NCCNHR has been an active voice against tort reform and for strong civil justice remedies.

Table of Contents,

I. Faces of Neglect: Behind the Closed Doors of Nursing Homes

II. Faces of Neglect Across the United States: What Does Resident Neglect and Abuse Look Like?

Faces of Neglect Across the U.S.:
What Does Resident Neglect and Abuse Look Like? *(continued)*

1 Faces of Neglect: Behind the Closed Doors Of Nursing Homes

Executive Summary

The pages of this book demonstrate the impact of neglect and abuse in long-term care facilities — not in statistics but in the tragic, real experiences of such productive members of society as homemakers and teachers, engineers and nurses.

Those depicted endured severe, unnecessary suffering at the most vulnerable time of their lives. The faces you see here could be those of your mother, father, grandmother, grandfather, sister, brother, or one day, yourself.

All but one of them were plaintiffs in lawsuits. As a result of poor care and weak enforcement of public laws regulating long-term care facilities, they and others like them — residents and their families — turned to the civil justice system as a last resort.

Most lawsuits against long-term care facilities are brought for multiple, serious omissions of care that cause life-threatening pressure sores, permanently contracted muscles, infections, broken bones, malnutrition, or dehydration. In spite of decades of congressional investigations and hearings showing egregious deficiencies in long-term care and poor enforcement of public regulations, Congress is considering legislation that, in practice, would prevent residents and their families from exercising their constitutional right to bring civil lawsuits against facilities that cause them irreparable harm or death. Proposed medical malpractice legislation, called "tort reform" by its proponents, would place severe caps on non-economic damages and would limit, if not end, residents' ability to be compensated in the courts when the regulatory system fails them.

The families of those profiled in this book have given us permission to tell their stories because, as one victim's daughter told us, she wants her mother's experience to make a difference for others.

The victims' experiences do not reflect those of all long-term care residents, nor do they negate the dedication and compassion of most workers in long-term care. Collectively, however, they tell the story of too many individuals who are ill-treated, ignored, or abused and for whom tort reform would mean losing a final opportunity to obtain recognition of the harm that was done to them and compensation from those who denied them compassion, dignity, and care.

Introduction

More than 2.5 million American elders and disabled adults live in nursing homes, assisted living facilities, and other board and care settings because they require around-the-clock nursing care and/or assistance. Some of these vulnerable adults suffer from neglect and abuse that can only be described as horrific. For them, and for their families, courts are the last resort and civil lawsuits are pleas for those responsible and our society to recognize their plight and keep others from suffering needlessly.

The purpose of this book is to improve understanding of why our society must preserve the right of long-term care residents, many of whom are in the last months or years of their lives, to seek justice. Their stories paint a heartrending picture of failure. Although several years have elapsed since the events in some of these cases occurred, each unfortunately illustrates the types of neglect and abuse that have prevailed in the long-term care industry for decades and continue today.

Neglect and Abuse

Despite federal and state regulation, regardless of the vigilance of dedicated health care workers and consumer advocates, and even with repeated media exposes and congressional hearings to bring conditions to light and provide solutions to the problems, neglect and abuse in long-term care facilities remain widespread.

Why do neglect and abuse persist? The reasons are complex, but the overwhelming reason is a chronic lack of enough well-trained and well-supervised nursing staff to provide necessary care. A 2001 federal study, based on research by leading experts in long-term care, documented that more than half of all nursing homes do not employ enough nursing staff to avoid harm to residents, and more than nine out of ten do not employ enough nurses and nursing assistants to provide good care. Ninety percent of care in nursing homes is given by nurse aides who struggle to do their jobs with little training, low pay, few benefits, minimal professional supervision, and limited resources. In 2002, annual turnover rates among nursing assistants exceeded 80 percent in 19 states, and exceeded 100 percent in 10 states.

Training and supervision of nursing home staff are often inadequate. A 2005 analysis of nursing home staffing data shows that the proportion of care provided by registered nurses is declining in spite of increases in Medicare funding earmarked for nursing. Moreover, the U.S. Department of Health and Human Services' Office of Inspector General found that only 38 percent of medical directors visit their nursing homes more than once a week.

Neglect Becomes Abuse

Repeated lack of basic care or failure to provide enough competent, well-screened employees transforms neglect into abuse. When residents are not repositioned often enough to prevent painful pressure sores from forming and worsening, neglect becomes abuse. In severe cases, which you will see in this book, pressure sores multiply and deepen until the bone is exposed; the resident may die from infection. When residents are allowed to remain in one position so long that their muscles contract, permanent, painful disability—called contractures—occurs. When residents with dementia are poorly supervised and wander from the facility, they may fall and break bones or die from exposure.

Neglect becomes abuse when facilities hire workers without doing criminal background checks and residents are beaten or raped by convicted felons. Malnutrition and dehydration (by some estimates affecting up to 85 percent of all residents nationwide) occur because the residents are not assisted with eating or provided liquids on a regular basis.

Neglect becomes abuse when workers, who are struggling with heavy workloads, low salaries, and inadequate benefits, are not adequately trained or supervised.

While pain and suffering are incalculable, poor care carries financial cost as well. The cost of neglect in dollars has never been fully calculated but is certain to be immense. In some of the case profiles, we quantify hospital expenses that stemmed from neglect, but we could not capture other costs, such as those for antibiotics and other medications, surgical procedures, high-tech alternating-pressure relief beds used to treat advanced pressure sores, feeding tubes and catheters, and increased medical attention.

"Woefully Deficient Care" and Poor Enforcement

In 2004, long-term care ombudsmen investigated nearly 20,000 complaints related to abuse, gross neglect, and exploitation, and over 87,000 complaints about resident care. Also in 2004, regulatory agencies cited 26.2 percent of nursing homes nationwide for violations related to quality of care. Many of the facilities where neglect and

abuse occur are repeat poor performers with long histories of serious, identified problems that state regulators have allowed to continue year after year. In fact, the U.S. Government Accountability Office's chief healthcare investigator told the Senate Finance Committee in 2003 that more than 300,000 elderly and disabled residents lived in chronically deficient nursing homes where they were "at risk of harm due to woefully deficient care." He said residents suffered serious harm or died "when physicians' orders were ignored, when residents were allowed to deteriorate due to malnutrition or dehydration without any intervention, or because bedsores went undiagnosed or . . . were not treated properly."

Despite the widespread evidence of neglect and abuse in nursing homes, residents and their loved ones often have little recourse when serious harm, injury, or even death results. Government studies show that state regulatory agencies also suffer from understaffing and have high turnover rates among their surveyors, creating a shortage of experienced investigators. According to the Government Accountability Office (GAO) and the Office of Inspector General, state survey agencies frequently fail to cite facilities for harming residents, even when they find serious injuries; and when facilities are cited for deficiencies, fines or other sanctions often fail to reflect the seriousness of the violations.

A December 2005 report by the GAO is the latest government finding that state surveyors understate deficiencies that cause harm to residents or put them in immediate jeopardy. The study found that in five states that had a significant decline in serious deficiencies from 1999 to 2005, 18 percent of federal comparative surveys identified at least one serious deficiency missed by state surveyors, ranging from a low of 8 percent in Ohio to a high of 33 percent in Florida. The study also notes that numerous GAO reports from 1998 to 2004 document serious problems with nursing homes and the survey and enforcement system, including: a proportion of facilities that repeatedly cause actual harm to residents or place residents at risk of death or serious injury; understatement by surveyors of the extent of serious quality of care problems; long delays in investigations of complaints from residents, family members and staff alleging harm to residents; the failure of enforcement policies to ensure that deficiencies are addressed and remain corrected; and limited effectiveness of federal mechanisms for overseeing the state survey system. Another recent study by the Office of Inspector General found that fines were sporadically levied by state survey agencies and, when levied, often were minimal and collected late or not at all.

Investigations of assisted living facilities reveal that care and public oversight in other long-term care settings may be no better than in nursing homes. For example, *The Washington Post* reported in May 2004 that Virginia records showed that "about 4,400 residents have been victims of abuse, neglect or exploitation since 1995" in assisted living facilities and that 51 deaths might have been attributable to poor quality care. According to a 2005 report by the National Senior Citizens' Law Center, only 19 states require hourly minimums for training of direct-care workers in assisted living and only 26 states require assisted living facilities to employ or contract with a nurse. Even in states that have this requirement, however, the nurse may not be required to be present at the facility but rather may review care plans or facility policies or be available only by phone.

Capping Access to Civil Justice

When a resident suffers egregious harm, and regulatory agencies do little or nothing to protect other residents or sanction the facility, some residents and family members turn to the courts to hold the facility accountable. All U.S. citizens have a fundamental right to seek justice before a jury when they are harmed. Yet, for those who live in long-term care facilities, this constitutional right is

now under attack in the U.S. Congress and many state legislatures.

In civil suits, the only way the court can compensate victims for injuries is by providing financial compensation for damages. Most civil cases involving persons who are in the workforce seek economic damages—reimbursement for out-of-pocket expenses like medical bills and lost wages or future earning potential. Non-economic damages are sometimes referred to as awards for "pain and suffering." Unlike reimbursement for economic damages, non-economic damages are the only compensation a jury can award for the injury or wrongful death itself.

Since economic damages are rarely an option for long-term care residents because they do not have an earned income or earnings potential, non-economic damages are the only remedy available to compensate for painful injuries, permanent loss of limbs, loss of ability to function, and death.

A Harvard University researcher estimated in testimony before the Senate Special Committee on Aging in 2004 that 80 percent of all compensation in nursing home lawsuits is for non-economic damages. He testified that caps on noneconomic damages would block the ability of injured residents and their families to hold nursing homes accountable for their negligence.

Unfortunately, medical malpractice bills that have been introduced by federal lawmakers and enacted into law by some state legislatures include such caps. The caps would limit noneconomic damages to $250,000 in health care lawsuits, including those against nursing homes and assisted living facilities, while allowing unlimited economic damages for the able-bodied.

The effective result of this is that it would become financially impossible for attorneys to bring cases for victims who do not have economic damages.

The costs of bringing a case to trial — the costs incurred in discovery, obtaining the testimony of expert witnesses, depositions, and research — can easily reach into the tens or even hundreds of thousands of dollars. When the cost of bringing a case approaches the maximum compensation a jury can provide under an artificial and arbitrary cap, legitimate cases will be locked out of the courtroom.

In contrast, a jury would have no limit on the amount it could award a corporate executive who brought a tort case for loss of income.

Limiting non-economic damages devalues the lives of older Americans and increases vulnerability to abuse and neglect of every citizen in his or her final years. We are all at risk.

Losing the Deterrent Effect

In addition to making it almost impossible for residents to bring lawsuits against nursing homes or assisted living facilities, the limit on damages would remove the deterrent effect that monetary penalties have had on facility behavior, especially on facilities that are owned by multi-million dollar corporations.

Indeed, the president of a health care insurer in Colorado says lawsuits are having a positive effect. He told an insurance trade journal that the nursing home industry is "correcting itself," conducting more background checks on workers and improving nurse staffing because more insurance carriers "will not take on the risk unless staffing ratios meet certain targets."

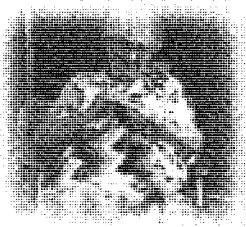
Most victims of neglect or abuse and their families bring lawsuits to prevent those injuries and indignities from happening to other residents. In the words of one family member interviewed in the course of this project, "I didn't want to file suit at first. I had never sued anyone before. But this should not have happened to my dad. I did it because changes had to be made." Another family

member said, "I decided to pursue a lawsuit so that my mother's story could be told and so her story could make a difference." Eliminating meaningful access to civil justice removes one of the last effective remedies in the struggle to improve care in American nursing homes and assisted living facilities.

The Story of Real People

What follows is not a statistical sampling or an examination of the breadth or depth of neglect in long-term care facilities. Rather, it is the story of real people who were neglected and abused, with terrible, often fatal, consequences. In response to these experiences, these individuals, or their loved ones, decided to exercise their constitutional right to civil justice. We trust that their stories will help you understand why it is in the best interests of all Americans to defend long-term care facility residents' access to civil justice.

We hope to bring home the fact that "reforms" in the tort system would bar elderly and disabled people in institutions from being adequately compensated for neglect and abuse. Finally, our goal is to someday eliminate the need for lawsuits by securing public policies that ensure adequate staffing, comprehensive person-directed care, and real quality of life in long-term care facilities.



II.

The Faces of Neglect

Across the United States

Resident: Katherine J.
State: Arizona
Type of Facility: Nursing Home
Residency: 6/22/2001 – 7/1/2001

THE BEFORE PICTURE

An introduction to Katherine J.

- Age: 72
- Life's occupation: Mother and homemaker
- Enjoyed cooking and sewing
- Volunteered with several organizations

Facility assessment of Katherine J. upon admission:

- Stage II* pressure sore on buttocks
- Type II diabetes
- Vitamin B12 deficiency
- Congestive heart failure*

A PROFILE IN NEGLECT

How Katherine J. was neglected:

- Mrs. J. was admitted to the nursing home on June 22, 2001, following an episode of loss of consciousness at her home, where she had been living independently, and a subsequent four-day hospitalization.
- She was not evaluated by either a registered nurse or physician at the nursing home until June 25, 2001, her fourth day at the facility.
- The hospital discharge summary noted a small blister with a reddened area on Mrs. J.'s buttocks. In the assessment done June 25, the nursing home admission nurse noted a vastly different description of the sore on Mrs. J.'s buttocks, indicating it was a large, foul-smelling, 11 inch x 13 inch pressure sore covering both buttocks.
- Physician orders for an egg crate mattress and, later, a pressure relief mattress for Mrs. J., were not followed.
- Mrs. J.'s son testified that he found his mother lying on her back whenever he visited, which was daily, even though she was admitted with a pressure sore on her buttocks.
- As a result, what was originally a Stage II pressure sore progressed to a massive Stage IV* pressure sore measuring 5 cm in diameter and 4.5 cm deep with tunneling* from the wound.
- The hospital physician who treated the pressure sore testified it was the worst pressure sore he had ever seen.
- Because of Mrs. J.'s weakness, her doctor ordered that her food be pureed; however, the facility failed to follow this order until the very end of her stay. As a result, Mrs. J. did not get the nutrition she needed to help her pressure sores heal.

(Note: Glossary terms used in the case description are marked with an *).

- Although staff records indicated that Mrs. J. ate well at almost all meals, Mrs. J.'s son testified that this was not true based on his personal observations during lengthy, daily visits with her. He often found his mother's dinner tray cold and untouched, far from her reach. Because of general weakness, Mrs. J. needed help with eating. Mrs. J.'s son never saw staff assist her with eating.
- Despite repeated nurses' notes documenting that Mrs. J. moaned, grimaced, and cried out in pain, staff failed to address her pain. Records show that at the nursing home she was only given an occasional Tylenol for pain, and then nothing for three days (June 25 – June 28, 2001). Just before she was transferred to the hospital on July 1, 2001, she received a few Darvocet* pills. Upon her admission to the hospital, hospital staff found that Mrs. J.'s pain was so severe that she was given Demerol* injections.
- Nursing home staff also failed to adequately clean Mrs. J.'s urinary catheter*. Hospital records noted that the catheter was dirty when she entered the hospital on July 1, 2001.
- A nurse's note on July 1, 2001, when Mrs. J. was transferred to the hospital, indicates that the reason for the transfer was the insistence of Mrs. J.'s son: "Family concerned about the patient's 'condition,' temperature of 100 F … and just not as responsive to son as before." Mrs. J.'s temperature upon admission to the hospital was 102.5 F; her heart rate was 130 per minute (adult normal = avg. 72 per minute), respirations were 30 per minute (normal for an adult at rest = 8-16 per minute), she was impacted, and diagnoses included sepsis and infected pressure sores.
- The hospital physician testified that this was the worst case of neglect he had ever seen in his practice.
- Mrs. J. died at the hospital on July 3, 2001, after undergoing debridement* of her pressure sore. Upon completion of the debridement, the sore measured 40 cm x 20 cm.
- The nursing home administrators testified that the systems of care at the nursing home were in "complete meltdown" and "massively broken" during the time Mrs. J. was a resident.

The human cost of neglect:

- Massive infected Stage IV sacral* pressure ulcer, requiring debridement and flap surgery*
- After debridement, Mrs. J. was left with a 40 cm x 20 cm gaping hole in her buttocks
- Untreated, severe pain
- Fecal impaction
- Death due to infection caused by pressure sores

The financial cost of neglect:

- $27,869 (hospital expenses)

ANY CONSEQUENCES TO THE FACILITY?

- Did the survey agency fine the facility for this neglect? ..... **No**
- What was the amount of fine actually paid? **$0**
- Did the survey agency deny payments for all new admissions of residents on Medicare/Medicaid? ..... **No**
- Did the survey agency place the facility on state monitoring status? ..... **No**
- Was the facility's license placed on probationary status or revoked for this neglect? ..... **No**
- Was this neglect criminally prosecuted? ..... **No**

Resident: Jessie T.
State: Arizona
Type of Facility: Nursing Home
Residency: 7/17/96 – 11/14/02

THE BEFORE PICTURE

An introduction to Jessie T.

- Age: 86
- Life's occupation: Homemaker
- 7 children
- Enjoyed sewing, baking, and gardening

Facility assessment of Jessie T. upon admission:

- Alzheimer's Disease
- Diabetes
- No pressure sores*
- No end-stage disease

A PROFILE IN NEGLECT

How Jessie T. was neglected:

- Four years after Mrs. T. entered the nursing home, in the fall of 2000, a nurse's note indicates that Mrs. T. had developed "bilateral arm" contractures*. Although nursing staff were aware of the development, they failed to take measures to prevent the contractures from worsening.
- Nursing notes on November 7, 2000, indicate that Mrs. T. had developed a Stage II* pressure sore on her coccyx*. A week later, the sore had progressed to Stage III* and measured 2 cm x 1 cm.
- After she developed both contractures and pressure sores in the fall of 2000, Mrs. T.'s care plan* was not changed in any way until 2001.
- Mrs. T.'s right tibia/fibula* was fractured and skin was torn when her leg was caught underneath her wheelchair in late September 2002.
- This incident and injury were not reported or documented. The leg fracture went undiscovered and untreated for over a month, leaving Mrs. T. in severe pain and unable to express her pain because of her dementia.
- By October 2002, Mrs. T. had developed pressure sores on her right heel that measured 8 cm x 6 cm with brown mucous and a foul odor with redness/inflammation around the site; on her right shin that measured 3 cm x 3.5 cm; on the side of her lower right leg that measured 9.5 cm x 2.5 cm; on the side of her left foot that measured 1 cm x 1.5 cm; and on her coccyx that measured 1.6 cm x 1.8 cm.
- In late October 2002, a wound care nurse called in to examine Mrs. T.'s pressure sores found Mrs. T.'s leg to be swollen and tender. She asked for an x-ray and discovered that her

tibia/fibula was fractured with offset of the fracture fragments, meaning that the fractures were unstable, and would cause great pain with movement.

- By the end of October 2002, Mrs. T. was admitted to the hospital for sepsis*, with multiple pressure sores and "extensive" contractures of her lower and upper extremities.
- She was discharged from the hospital to a hospice on November 14, 2002, and died from pneumonia on November 20, 2002.

THE AFTER PICTURE

Pressure sore on right heel.

The human cost of neglect:

- Multiple large, infected pressure sores
- Extensive contractures*
- Untreated leg fracture
- Severe pain for approximately one month due to unstable fracture

The financial cost of neglect:

- Unknown

ANY CONSEQUENCES TO THE FACILITY?

- Did the survey agency fine the facility for this neglect? ..... **No**
- What was the amount of fine actually paid? **$0**
- Did the survey agency deny payments for all new admissions of residents on Medicare/Medicaid? ..... **No**
- Did the survey agency place the facility on state monitoring status? ..... **No**
- Was the facility's license placed on probationary status or revoked for this neglect? ..... **No**
- Was this neglect criminally prosecuted? ..... **No**

3.

Resident: Isabel G.
State: Arkansas
Type of Facility: Nursing Home
Residency: 4/21/2003 – 6/24/2004

THE BEFORE PICTURE

An introduction to Isabel G.

- Age: 70
- Life's occupation: Homemaker
- 5 children
- Before entering the facility, had lived at home with assistance from her children

Facility assessment of Isabel G. upon admission:

- End stage renal* disease
- Insulin dependent diabetes
- Osteomyelitis* of spine
- Rheumatoid arthritis
- Lumbar disc disease
- Congestive heart failure*
- Small superficial pressure sore* measuring 1 cm on coccyx*

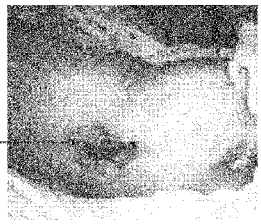
A PROFILE IN NEGLECT

How Isabel G. was neglected:

- Although Mrs. G. was admitted to the nursing home on April 21, 2003, with a small pressure sore, it healed within six weeks of her admission.
- Mrs. G. required little assistance with her basic care needs until she suffered a mild stroke on November 19, 2003.
- After her stroke, Mrs. G. became dependent on facility staff for her basic needs and could no longer reposition herself in bed.
- Nursing home staff failed to take preventive measures, and Mrs. G. suffered recurrent problems with the development of pressure sores on her coccyx* from November 2003 through April 2004.
- Within six weeks from late May to early June of 2004, Mrs. G. developed four new Stage II* pressure sores on her hip, buttocks and lower back.
- Despite the development of these multiple sores, the facility did not turn and reposition her every two hours, and did not provide Mrs. G. with an adequate pressure-relieving mattress until just before her final discharge.

- On June 21, 2004, the nursing home noted an inflamed area with dead tissue and redness on her lower back. Instead of immediately seeking appropriate treatment, nursing staff made an appointment for Mrs. G. to see a doctor three days later.
- On June 24, 2004, the day Mrs. G. was to be taken to the doctor's appointment, Mrs. G.'s daughter found her unresponsive in her nursing home bed. Mrs. G. was transported to the local hospital only after her daughter insisted.
- Although Mrs. G. was transported to the hospital at 1:30 p.m. on June 24, 2004, the nursing home falsely documented testing her blood sugar at 6:00 p.m. that evening.
- At the hospital, Mrs. G. was diagnosed with dehydration and sepsis, diabetic ketoacidosis*, severely infected pressure sores, severe pain and malnutrition.
- The pressure sore on her lower back was found to be a deep Stage IV* pressure sore extending to the bone, measuring 8 cm x 5 cm, foul smelling, with green mucoid drainage.
- Cultures of the pressure sore on Mrs. G.'s lower back revealed infection with MRSA* (Methacillin Resistant Staphylococcus Aureus), and, despite treatment with intravenous antibiotics, Mrs. G.'s condition continued to deteriorate, and she died from the infection.

THE AFTER PICTURE



Pressure sore on lower back.

The human cost of neglect:

- Multiple severely infected pressure sores
- Sepsis*
- Death

The financial cost of neglect:

- Unknown

ANY CONSEQUENCES TO THE FACILITY?

- Did the survey agency fine the facility for this neglect?.....No
- What was the amount of fine actually paid?.....$0
- Did the survey agency deny payments for all new admissions of residents on Medicare/Medicaid?.....Yes
- Did the survey agency place the facility on state monitoring status?.....No
- Was the facility's license placed on probationary status or revoked for this neglect?.....No
- Was this neglect criminally prosecuted?.....No

4

Resident: Leslie H.
State: Arkansas
Type of Facility: Nursing Home
Residency: 6/8/2001 – 8/31/2001

THE BEFORE PICTURE

An introduction to Leslie H.

- Age: 82
- Life's occupation: Store owner
- Three children

Facility assessment of Leslie H. upon admission:

- Parkinson's Disease
- Congestive heart failure*
- Depression
- Extensively dependent on staff for help with toileting, dressing/grooming, and transferring*
- Unable to walk
- One Stage II* pressure sore* on left heel measuring 1 cm x .6 cm

A PROFILE IN NEGLECT

How Leslie H. was neglected:

- Over the period of Mr. H.'s three month stay at the nursing home beginning in June 2001, the facility failed to provide him with psychosocial* services and adequate pressure relief and nutritional interventions to prevent and treat thirteen pressure sores.
- On June 12, 2001, four days after he was admitted to the nursing home, Mr. H. was sent to the hospital for treatment of bleeding caused when he pulled out his foley catheter*. Upon readmission to the nursing home, Mr. H. had a Stage II pressure sore on his coccyx*.
- The nursing home's assessment completed June 15, 2001, stated that Mr. H. weighed 150 lbs. and that his appetite was good. Over the next two months, the nursing home's meal consumption records indicated that he was eating less and less.
- As Mr. H. lost weight over the summer, he developed numerous pressure sores which were not prevented by the facility.
- A pressure-relieving mattress was provided but no apparent reassessment was completed when additional pressure sores developed. No alternate mattress to provide improved pressure relief was ordered when the first mattress proved ineffective.

- Although Mr. H.'s physician had ordered that he be offered nutritional supplements if he ate less than half of his meals, the nursing home's documentation shows that he was not consistently offered supplements when he ate less than half of his meals.
- In mid-August, Mr. H.'s physician ordered that he be evaluated by a speech therapist. Mr. H. was found to have moderate to severe difficulty swallowing and was placed on a pureed diet.
- Mr. H. lost 33.5 lbs. in the two month period between the end of June and the end of August.
- Despite this steady weight loss, no appetite stimulant was ordered, nor was the option of insertion of a feeding tube discussed with Mr. H. or his family until late August 2001.
- The nursing home's assessment completed August 25 states: "Often resident does not want to eat and does not finish his meal," and that "resident seen by MD and states he has 'given up.'"
- Despite Mr. H.'s alarming weight loss, Mr. H.'s wife and daughter often observed nursing home staff leaving Mr. H.'s tray at his beside without encouraging him or assisting him with eating.
- The facility also failed to monitor Mr. H.'s fluid intake and provide him with sufficient fluid intake. As a result, Mr. H. became severely dehydrated. Mr. H.'s care plan* called for his fluid intake to be recorded by nursing staff in cc's, but this was not done.
- A physician note on another occasion stated that Mr. H. had a "strong desire to die which we have addressed with he and his wife on repeated occasions." Despite this assessment by the physician, no anti-depressant was ordered or psychosocial services provided.
- As a result of the facility's failure to provide adequate pressure relief, Mr. H. developed thirteen pressure sores between the beginning of June and the end of August 2001, including a Stage IV* pressure sore on his coccyx.
- Mr. H. died in the hospital of acute renal* failure caused by urosepsis* on September 11, 2001, with thirteen pressure sores.

The human cost of neglect:

- Thirteen pressure sores
- Malnutrition
- Dehydration
- Severe weight loss
- Death

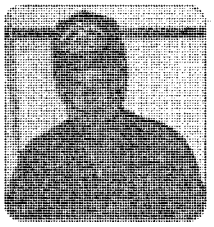
The financial cost of neglect:

- Unknown

ANY CONSEQUENCES TO THE FACILITY?

- Did the survey agency fine the facility for this neglect? **No**
- What was the amount of fine actually paid? **$0**
- Did the survey agency deny payments for all new admissions of residents on Medicare/Medicaid? **Yes**
- Did the survey agency place the facility on state monitoring status? **No**
- Was the facility's license placed on probationary status or revoked for this neglect? **No**
- Was this neglect criminally prosecuted? **No**

5.



Resident: Hugh T.
State: Arkansas
Type of Facility: Nursing Home
Residency: 10/6/97 – 9/13/01

THE BEFORE PICTURE

An introduction to Hugh T.

- Age: 58
- Life's occupation: Master electrician
- Married with three children

Facility assessment of Hugh T. upon admission:

- Central nervous system vasculitis*
- Multiple strokes
- No pressure sores
- No malnutrition
- Totally dependent on staff for help with eating, dressing/grooming, toileting, and transferring*

A PROFILE IN NEGLECT

How Hugh T. was neglected:

- After being admitted to the nursing home in 1997, Mr. T. began having difficulty swallowing in spring of 2001. Mr. T.'s physician ordered a swallow study on June 13, 2001. Swallow studies are used to diagnose patients who are having difficulty swallowing and who may be "aspirating" food or fluid into the lungs. If aspiration* is detected, the consistency of a person's food may be changed (e.g., pureed) to facilitate swallowing, or tube feeding may be recommended.
- Nursing staff failed to arrange for the swallow study ordered by the physician. By September 13, 2001, Mr. T. was hospitalized with aspiration pneumonia*, which might have been avoided if Mr. T.'s aspiration had been diagnosed and adjustments to his diet had been made in June.
- During his residency at the facility, Mr. T. repeatedly developed severe urinary tract infections because regular and thorough incontinence care was not provided.
- On one occasion, nursing staff failed to obtain a urine analysis that was ordered by his physician. When Mr. T. was admitted to the hospital in September 2001, he was also diagnosed with a severe urinary tract infection, acute renal failure and kidney inflammation with sepsis*.
- Mr. T. sustained numerous injuries while in the nursing home. He experienced skin tears* on October 21, 2000, March 11, 2001, March 17, 2001, and an injury on October 10, 2000, that

partially ripped his toenail from the nail bed. Mr. T. could not have caused these injuries himself because he was bed bound and immobile without assistance from staff.

- As a result of Mr. T.'s toe injury, his toe had to be debrided*. Additionally, Mr. T. suffered a head injury on January 12, 2001, after a light fixture fell off the wall and onto his head.
- Nursing staff failed to provide Mr. T. with a proper mattress and regular turning and repositioning to prevent the development of pressure sores. Mr. T. developed multiple Stage II pressure sores* on his sacrum* between June 2000 and September 2001.

The human cost of neglect:

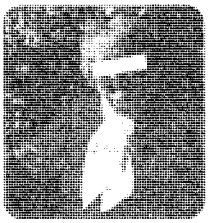
- Multiple pressure sores
- Recurrent urinary tract infections
- Kidney inflammation leading to acute renal* failure
- Aspiration pneumonia*
- Sepsis
- Head injury
- Skin tears*

The financial cost of neglect:

- Unknown

ANY CONSEQUENCES TO THE FACILITY?

- Did the survey agency fine the facility for this neglect?.....**No**
- What was the amount of fine actually paid? .....**No**
- Did the survey agency deny payments for all new admissions of residents on Medicare/Medicaid? .....**No**
- Did the survey agency place the facility on state monitoring status?.....**No**
- Was the facility's license placed on probationary status or revoked for this neglect?.....**No**
- Was this neglect criminally prosecuted?.....**No**



Resident: Annamarie D.†
State: California
Type of Facility: Nursing Home
Residency: 1996 – 5/25/2000

THE BEFORE PICTURE

An introduction to Annamarie D.

- Age: 88
- Life's occupation: Mother
- 2 children

Facility assessment of Annamarie D. upon admission:

- No pressure sores*
- Alzheimer's disease
- Non-insulin dependent diabetes
- At risk for falls
- Partially dependent on staff for help with toileting, dressing/grooming, eating, and walking

A PROFILE IN NEGLECT

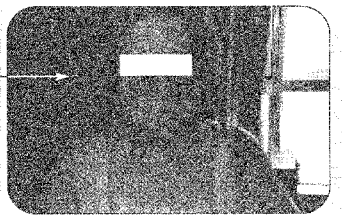
How Annamarie D. was neglected:

- A facility nurse stated under oath, "As a result of the serious understaffing at the facility, there were numerous instances of violence among the residents. Residents like Mrs. D. in the Alzheimer's unit were often attacked by the more violent, combative and uncontrollable residents."
- Mrs. D. was assaulted several times at the facility by other residents. Regarding an assault on February 9, 2000, a facility nurse testified, "I recall that Mrs. D. was attacked and beaten up by one of the 'predator' residents while I was working at the facility....I recall that as a result of this attack, Mrs. D. had suffered a broken arm or broken wrist and some facial wounds, which I treated."
- The assault on February 9, 2000, broke Mrs. D.'s wrist, terrified her, and led to a general decline in her abilities. Over the next few months, she became bed-bound. When staff failed to reposition her every two hours, she developed severe pressure sores on both of her heels.
- The facility covered up Mrs. D.'s heel sores. When her son inquired about the coverings, a charge nurse told him that Mrs. D. had some "blisters" but falsely stated that there was nothing to worry about. As a result, Mrs. D.'s son did not advocate for or monitor treatment of the sores.
- Meanwhile, staff failed to properly treat the pressure sores. The sore on the left heel developed into an untreatable Stage IV* wound measuring 10 cm x 7.9 cm and penetrating to the bone, with osteomyelitis* and sepsis*.
- Mrs. D. was sent to a hospital for wound care on May 25, 2000. Hospital physicians found her sores to be so infected that they recommended amputation of her left leg in order to save her life.

† Fictionalized name to respect the family's wish not to use the resident's real first name.

- Because Mrs. D. had Alzheimer's disease and was unable to make decisions for herself, her son had to decide whether to pursue amputation. Mrs. D's son knew his mother would not want that, so she was given comfort care until she died on August 28, 2000.
- A facility nurse stated under oath, "From my direct observations and work at the facility, corporate management ignored and prevented correcting problems at the facility because it would not be cost effective and financially profitable."

THE AFTER PICTURE



The human cost of neglect:

- Bruises and pain from physical assaults by other residents
- Fractured wrist
- Greatly decreased mobility following the February 2000 assault
- Stage IV* pressure sore on left heel and Stage III* pressure sore on right heel
- Severe infection of pressure sores
- Death

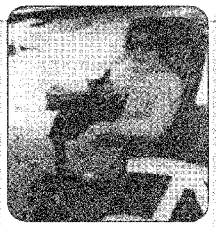
The financial cost of neglect:

- $105,071.29 (hospital expenses)

ANY CONSEQUENCES TO THE FACILITY?

- Did the survey agency fine the facility for this neglect? ..... **Yes**
- What was the amount of fine actually paid? ..... **$7,500 (reduced from $20,000)**
- Did the survey agency deny payments for all new admissions of residents on Medicare/Medicaid? ..... **Yes, for 3 months**
- Did the survey agency place the facility on state monitoring status? ..... **Yes**
- Was the facility's license placed on probationary status or revoked for this neglect? ..... **No**
- Was this neglect criminally prosecuted? ..... **No**
- Was action taken by the nursing home administrator licensing board? ..... **No**
- Was action taken by the physician licensing board? ..... **No**
- Was action taken by the nurse licensing board? ..... **No**

7.



Resident: Jean M. †
State: California
Type of Facility: Nursing Home
Residency: 2/14/2004 – 3/12/2004

THE BEFORE PICTURE

An introduction to Jean M.

- Age: 75
- Life's occupation(s): Parliament cigarette ad model; nurse; attorney
- Very independent; had lived alone in her condo prior to breaking her hip
- Enjoyed the warm California weather

Facility assessment of Jean M. upon admission:

- Fractured right hip
- Chronic obstructive pulmonary disease*
- Stage I* pressure sores on heels and buttocks
- Totally dependent on staff for help with transferring* and bed mobility

A PROFILE IN NEGLECT

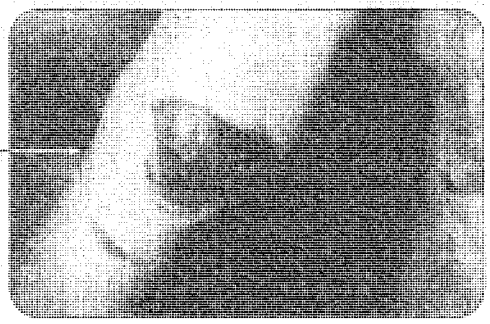
How Jean M. was neglected:

- Ms. M. had been living independently in her own condominium prior to the fall that broke her hip. She was admitted to the nursing home for rehabilitation to allow her to return to living independently in her own home.
- Upon her admission to the nursing home, Ms. M.'s doctor ordered treatment for Stage I pressure sores on both of her heels and buttocks three times a day.
- During the first fifteen days of her residency, nursing staff failed to provide this prescribed treatment on numerous occasions.
- Despite the presence of Stage I pressure sores on Ms. M.'s heels and buttocks, nursing staff failed to perform regular skin status assessments and to utilize pressure relieving devices.
- Nursing staff also failed to develop and implement a turning schedule for Ms. M. In fact, according to nursing home records, there is no indication that Ms. M. was turned or repositioned at all during her stay.
- The Stage I pressure sores on Ms. M.'s heels progressed to Stage II* pressure sores. Nursing staff failed to update Ms. M.'s care plan* to address the worsening of the sores.
- On March 6, 2004, the pressure sore which existed at Stage I when Ms. M. was admitted was noted on her left buttock. At the time it was noted and treatment began, it already measured 2 cm x 4 cm and had advanced to Stage III*.
- Upon discovering this new pressure sore, nursing staff failed to notify Ms. M.'s physician for three days. By that time, the sore had increased further in size and had an area of necrosis*. It later became a Stage IV* pressure sore.

† Fictionalized name to respect the family's wish not to use the resident's real first name.

- At the time of her discharge from the facility, four of Ms. M.'s sores measured as follows: left heel, 4 cm x 6 cm; left buttock: 5 cm x 4 cm; right posterior leg: 6 cm x 7 cm; right heel: 6 cm x 4 cm.
- During her residency, three additional pressure sores present on Ms. M.'s body were not documented or treated by nursing staff. Those sores were discovered upon her discharge and admission to another facility.
- Nursing staff failed to treat Ms. M. with dignity and respect. They placed her in diapers even though she was not incontinent and allowed her to remain in soiled diapers for extended periods of time.
- Due to the pain caused by the pressure sores, Ms. M. was unable to complete the physical therapy she needed following hip surgery, causing her to become debilitated and unable to return to living independently.
- Ms. M.'s sores healed completely when she was discharged and was cared for at another facility, but she was not able to regain her independence due to the lack of post-operative physical therapy and had to remain in a nursing home for the rest of her life.

THE AFTER PICTURE



The human cost of neglect:

- Four large, Stage III and IV pressure sores
- Three undetected, untreated pressure sores
- Loss of independence due to inability to pursue physical therapy

The financial cost of neglect:

- $6,000 (wound care expenses)

ANY CONSEQUENCES TO THE FACILITY?

- Did the survey agency fine the facility for this neglect? ..... **No**
- What was the amount of fine actually paid? **$0**
- Did the survey agency deny payments for all new admissions of residents on Medicare/Medicaid? ..... **No**
- Did the survey agency place the facility on state monitoring status? ..... **No**
- Was the facility's license placed on probationary status or revoked for this neglect? ..... **No**
- Was this neglect criminally prosecuted? ..... **No**

8

Resident: Albert S.
State: California
Type of Facility: Nursing Home
Residency: 8/27/02 – 1/25/03

THE BEFORE PICTURE

An introduction to Albert S.

- Age: 79
- Life's occupation: Structural engineer
- Four children, two grandchildren
- Decorated veteran of WWII
- Married for 55 years

Facility assessment of Albert S. upon admission:

- Broken hip
- Transverse myelitis*
- Totally dependent on staff for help with dressing/grooming, walking, bathing, and transferring*

A PROFILE IN NEGLECT

How Albert S. was neglected:

- Although Mr. S. was able to feed himself when he was admitted to the facility in August 2002, nursing staff noted in their admission assessment that he had nutritional problems, leaving 25% to 75% of his food uneaten at meals. Nursing staff therefore initiated a care plan to address weight loss and dehydration.
- Nursing staff failed to implement this care plan, resulting in weight loss and severe dehydration.
- Sometime between January 16 and 20, 2003, Mr. S. aspirated* food into his lungs while he was eating.
- Between January 20 and 25, Mr. S. became "difficult to arouse," developed a temperature of 101 degrees, had a significant deterioration in blood pressure, developed slurred speech, and, finally, developed a cough with "greenish yellow secretions," a high fever and cloudy urine.
- This problem was left untreated by facility staff for five days despite the onset of this succession of alarming symptoms.
- Staff failed to notify Mr. S.'s physician of his change in level of consciousness and other symptoms and did not take his vital signs. The physician said, "I would have sent him out to the hospital for any change in his level of consciousness....I had no idea this was going on."
- On January 25, 2003, nurses noted that Mr. S. was very pale, had twitching arms and milky urine that contained blood, and was unable to respond verbally.

- Even after these findings, facility staff took no action to help Mr. S. until his daughter repeatedly requested that they send him to the hospital.
- Upon his admission to the hospital on January 25, Mr. S. was found to be suffering from aspiration pneumonia*, profoundly dehydrated, and severely malnourished. Mr. S. died of aspiration pneumonia and renal* failure due to dehydration on January 28.
- In the preceding two years, the facility had been cited seven times for similar violations such as failure to identify resident care needs, failure to implement a care plan, and failure to notify physicians of a change in medical condition.
- The Department of Health Services determined that the nursing staff's failure to assess Mr. S., update his care plan, and notify the physician of changes were a "direct proximate cause" of his death.

The human cost of neglect:

- Aspiration pneumonia*
- Renal failure* due to severe dehydration
- Death

The financial cost of neglect:

- $59,264 (hospital expenses)

ANY CONSEQUENCES TO THE FACILITY?

- Did the survey agency fine the facility for this neglect? ..... **Yes**
- What was the amount of fine actually paid? ..... **$10,000 (reduced from $75,000)**
- Did the survey agency deny payments for all new admissions of residents on Medicare/Medicaid? ..... **No**
- Did the survey agency place the facility on state monitoring status? ..... **No**
- Was the facility's license placed on probationary status or revoked for this neglect? ..... **No**
- Was this neglect criminally prosecuted? ..... **No**

Resident: Virginia C.
State: Colorado
Type of Facility: Nursing Home
Residency: 8/26/2000 – 2/14/2001

THE BEFORE PICTURE

An introduction to Virginia C.

- Age: 76
- Life's occupation: Grocery checker
- Enjoyed walking her dog nightly and line dancing

Facility assessment of Virginia C. upon admission:

- Slight dementia
- Partially dependent on staff for help with eating, dressing/grooming, and walking
- Stage I* pressure sore on coccyx
- At high risk for pressure sores

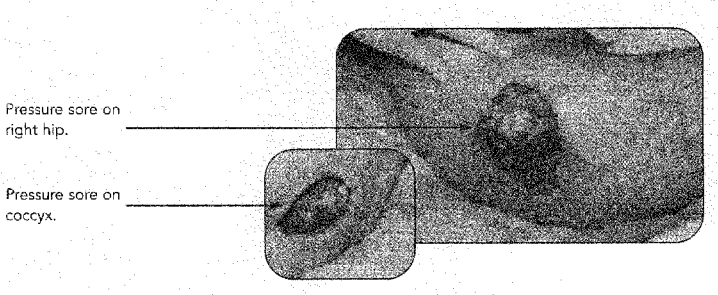
A PROFILE IN NEGLECT

How Virginia C. was neglected:

- Mrs. C. was admitted to the nursing home on August 26, 2000, with a reddened area on her coccyx. Nursing staff failed to recognize that the reddened area was, in fact, a Stage I pressure sore.
- On August 29, 2000, only a few days after Mrs. C.'s admission, nursing staff noted that the reddened area on her coccyx had progressed to a Stage II* pressure sore. Despite noting this change, staff failed to notify Mrs. C.'s physician, and failed to initiate appropriate measures to treat the pressure sore and prevent others from developing.
- On September 8, 2000, Mrs. C.'s pressure sore measured 6 cm x 5 cm with yellow-green eschar*. Mrs. C.'s care plan was revised to require staff to turn her every hour. Nursing staff failed to implement this care plan*, and by September 11, Mrs. C's pressure sore had progressed to a Stage III* sore.
- By September 16, 2000, Mrs. C.'s pressure sore measured 7 cm x 2 cm with 8 cm of redness around the sore. Facility records show that Stage I pressure sores had also developed on Mrs. C.'s hips.
- On September 23, 2000, nursing staff noted that Mrs. C. had a "10 cm mushy area" around the pressure sore on her coccyx, but failed to recognize that the "mushy area" was a sign of deep tissue injury.
- On September 28, 2000, the facility wound care nurse ordered that Mrs. C.'s pressure sore be "left open to air at night" without recognizing that this action increased the risk for infection and fecal contamination, and allowed the sore to dry out completely.

- By November 12, 2000, Mrs. C.'s coccyx pressure sore had worsened to a Stage IV* pressure sore exposing muscle and bone. She had several Stage II pressure sores on her right hip as well.
- By December 9, 2000, Mrs. C. had a 3 cm pressure sore on her left hip, had three pressure sores on her right hip and the Stage IV pressure sore on her coccyx had purple discoloration on the outside edge.
- By January 6, 2001, the pressure sores on Mrs. C's right and left hips had become open wounds and the facility wound care nurse ordered that they be treated with wet to dry betadine* soaked gauze dressings, a form of wound treatment detrimental to wound healing.
- By January 10, 2001, the pressure sore on Mrs. C.'s left hip had more than doubled in surface area.
- Finally, by February 14, 2001, Mrs. C. had Stage IV pressure sores on her coccyx and both of her hips. Mrs. C.'s husband had her transferred to another nursing home, concluding that the facility was not providing acceptable quality of care.

THE AFTER PICTURE



The human cost of neglect:

- Severe Stage IV pressure sores on her right and left hips and coccyx exposing muscle and bone
- Severe wound infections
- Extreme pain

The financial cost of neglect:

- Unknown

ANY CONSEQUENCES TO THE FACILITY?

- Did the survey agency fine the facility for this neglect? ..... **No**
- What was the amount of fine actually paid? **$0**
- Did the survey agency deny payments for all new admissions of residents on Medicare/Medicaid? ..... **No**
- Did the survey agency place the facility on state monitoring status? ..... **No**
- Was the facility's license placed on probationary status or revoked for this neglect? ..... **No**
- Was this neglect criminally prosecuted? ..... **No**

10

Resident: Frances R.
State: Colorado
Type of Facility: Nursing Home
Residency: 1/12/01 – 2/8/01

THE BEFORE PICTURE

An introduction to Frances R.

- Age: 86

Facility assessment of Frances R. upon admission:

- Congestive heart failure*
- Irregular heartbeat
- Chronic airway obstruction
- Alert and oriented

A PROFILE IN NEGLECT

How Frances R. was neglected:

- After a month at the facility, on February 3, 2001, Mrs. R. experienced a significant change in condition precipitated by a viral flu.
- She experienced diarrhea, weakness, nausea and vomiting, and consumed very little food and water.
- Prior to getting the flu, the facility's dietitian had assessed Mrs. R. as needing 1600 cc's of fluid per day based on her height and weight.
- Between February 3 and February 7, 2001, Mrs. R. took in only an average of 672 cc's per day — less fluid than the amount her body required when healthy, and far less than she needed given her additional need for fluids due to diarrhea and vomiting. Common interventions, such as a medical assessment, administration of intravenous fluids, or treatment for diarrhea and vomiting were not taken to address this severe fluid deficit.
- Facility staff failed to notify Mrs. R.'s physician about her change in condition or to consult with him about her medications, which included two high-dose diuretics*. The use of diuretics is contraindicated for people who are dehydrated because they are designed to increase the excretion of fluid from the body. Even though Mrs. R. was losing fluids and drinking poorly, nursing staff continued to administer the diuretics when her physician should have been consulted and the diuretics should have been discontinued.
- Nursing staff also failed to notify Mrs. R.'s family of her illness until just before her hospitalization, five days after her symptoms began.

- On February 8, 2001, Mrs. R. was admitted to the hospital in critical condition. She was diagnosed with dehydration, high potassium, and renal* failure. Her mental status had decreased, and she had difficulty walking. The admitting physician documented that she had been "having diarrhea 4–5 times per day for the last 4–5 days." Both her diuretics were immediately discontinued.

The human cost of neglect:

- Severe dehydration

The financial cost of neglect:

- Unknown

ANY CONSEQUENCES TO THE FACILITY?

- Did the survey agency fine the facility for this neglect?.....No
- What was the amount of fine actually paid?.....$0
- Did the survey agency deny payments for all new admissions of residents on Medicare/Medicaid?.....No
- Did the survey agency place the facility on state monitoring status?.....No
- Was the facility's license placed on probationary status or revoked for this neglect?.....No
- Was this neglect criminally prosecuted?.....No

11

Resident: Karen R.
State: Colorado
Type of Facility: Nursing Home
Residency: mid 2001 - mid 2005

THE BEFORE PICTURE

An introduction to Karen R.

- Age: 78

Facility assessment of Karen R. upon admission:

- Alzheimer's Disease
- Very limited capacity to communicate
- Diabetes
- Hypothyroidism*

A PROFILE IN NEGLECT

How Karen R. was neglected:

- Mrs. R. was raped twice by one of her male caregivers while a resident at the facility. The staff person who was the rapist had a felony conviction for stealing but had been certified as a nursing assistant (CNA) by the State.
- The facility claimed to have performed a background check on the CNA and found no evidence of criminal history. However, readily available public records revealed judicial domestic violence and divorce reports in which a former spouse alleged she was raped by him during their marriage, and their female child reported to a psychologist that he had sexually molested her. These records were in the same county as the nursing home.
- The caregiver first raped Mrs. R. in late 2004. Mrs. R. suffered broken teeth, a severe laceration, and vaginal bleeding as a result of the assault. In the nursing home chart, the rape was reported as just a late evening "fall."
- A few hours after the rape, a nurse saw Mrs. R.'s vaginal bleeding when she prepared to catheterize* her for a urinalysis. The nurse did not report the bleeding to Mrs. R.'s doctor.
- Mrs. R. was seen by her doctor the next morning for her head injuries, however, her vaginal bleeding was not reported.
- The doctor sent Mrs. R. to the hospital for testing related to her head injuries. Because the facility also failed to inform the hospital about her vaginal bleeding, no genitorectal evaluation was performed. No rape kit was used.

- The vaginal bleeding went unreported and un-assessed. There was no investigation for sexual assault.
- The same caregiver raped Mrs. R. again about 6 months later.
- The bleeding from the second rape did not stop for three days. As in the first rape, no rape kit or investigation for sexual assault was used with regard to this highly traumatic second rape.
- The only reason these rapes were discovered is because after the second rape, the rapist confessed to his minister. The minister persuaded him to turn himself in to the police.
- As part of the confession, the rapist admitted that Mrs. R.'s head injuries occurred while he was cleaning her up on the bed after he had "ejaculated" in her. She fell over, hit the floor, and there was blood everywhere.
- The facility had been cited by state regulators for inadequate background checks just months before the assaults occurred. After the rapist's confession, further investigation by the health department led to serious citations for failure to adequately investigate the first incident where vaginal bleeding had been noted, but was not assessed.
- After the rapist's confession, Mrs. R. was moved to another facility.
- The rapist took a plea bargain and is expected to be sentenced to 15 years to life on an indeterminate sentence.

The human cost of neglect:

- Two traumatic sexual assaults
- Severe head injuries and broken teeth

The financial cost of neglect:

- No financial cost because no treatment was given

ANY CONSEQUENCES TO THE FACILITY?

- Did the survey agency fine the facility for this neglect?.....**No**
- What was the amount of fine actually paid?.....**None**
- Did the survey agency deny payments for all new admissions of residents on Medicare/Medicaid? .....**No**
- Did the survey agency place the facility on state monitoring status? .....**No**
- Was the facility's license placed on probationary status or revoked for this neglect? .....**No**
- Was this neglect criminally prosecuted? .....**Yes. Rapist took a plea bargain and is expected to be sentenced to 15 years to life on an indeterminate sentence**

12

Resident: Evelyn S.
State: Colorado
Type of Facility: Nursing Home
Residency: 1/12/01 – 4/16/02

THE BEFORE PICTURE

An introduction to Evelyn S.

- Age: 84
- Enjoyed ongoing familial closeness

Facility assessment of Evelyn S. upon admission:

- Alzheimer's Disease
- Alert and oriented to her family

A PROFILE IN NEGLECT

How Evelyn S. was neglected:

- After living in the nursing home for more than one year, Mrs. S. developed severe periodontal disease*. The infection caused her severe pain which forced her to stop eating. Prior to her untreated mouth infection she had been eating and drinking.
- Mrs. S.'s husband desperately attempted to get treatment for Mrs. S. He contacted her dentist, who prescribed antibiotics; however, when Mrs. S.'s husband brought the antibiotics to the facility on April 4, 2002, nursing staff failed to administer them until April 8, 2002.
- Facility staff charted that Mrs. S. was consuming no fluids and no food for 8 days but did nothing about it.
- No nursing notes assessing her inability to eat or drink and her decline appear in her record until April 5, 2002, five days after she had stopped eating. Subsequent notes indicated a clear awareness by staff of the decline but no effective interventions.
- Although Mrs. S. had not eaten or had anything to drink for 8 days, the facility did not notify her physician, have her evaluated by a dietitian, puree her food, discuss parenteral* support or tube feeding with her family or hospitalize her.
- On April 8, 2002, Mrs. S.'s daughter arrived from out of town and found her mother unresponsive. She insisted that Mrs. S.'s doctor and the facility's Medical Director be called.
- The next day Mrs. S.'s doctor ordered the administration of intravenous fluids. However, even after the administration of intravenous fluids was ordered, nursing staff did not carry out the doctor's order until hours later.
- The antibiotics ordered by Mrs. S.'s dentist were finally administered on April 8, 2002 – four days after they were delivered to the facility by Mrs. S.'s husband.

- After Mrs. S. had not been eating or drinking for close to 10 days, the nursing home finally discharged her to a hospital.
- Upon admission to the hospital, Mrs. S. was unresponsive. Her sodium level was astronomically high to the point of causing brain damage. This was the result of very severe dehydration. She was also found to be severely malnourished.
- Mrs. S. died on April 16, 2002. Mrs. S.'s death certificate stated that she died of Acute Renal Failure due to "hypernatremia severe and dehydration severe."
- The facility was cited by regulators for failing to appropriately assess and provide care to Mrs. S. when her food and fluid intake declined and failing to inform her physician of a significant change in her condition.

The human cost of neglect:

- Dehydration
- Malnutrition
- Brain damage
- Death

The financial cost of neglect:

- Unknown

ANY CONSEQUENCES TO THE FACILITY?

- Did the survey agency fine the facility for this neglect?.....No
- What was the amount of fine actually paid? $0
- Did the survey agency deny payments for all new admissions of residents on Medicare/Medicaid? .....No
- Did the survey agency place the facility on state monitoring status?.....No
- Was the facility's license placed on probationary status or revoked for this neglect?.....No
- Was this neglect criminally prosecuted? .....No

13.

Resident: Emily A.
State: Florida
Type of Facility: Nursing Home
Residency: 12/05/01 – 04/24/02

THE BEFORE PICTURE

An introduction to Emily A.

- Age: 84
- Life's occupation: Homemaker
- 1 child, 2 grandchildren
- Deeply valued her relationships with friends and family

Facility assessment of Emily A. upon admission:

- Recently suffered a stroke with right side weakness
- At risk for pressure sores*
- No open areas or skin breaks
- Totally dependent on staff for help with toileting, dressing/grooming, walking, and transferring*
- Received nutrition via a feeding tube

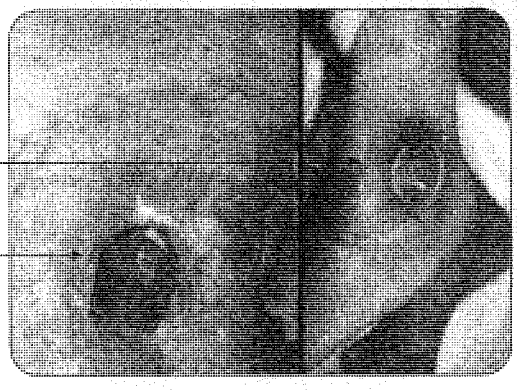
A PROFILE IN NEGLECT

How Emily A. was neglected:

- Upon Mrs. A.'s admission to the nursing home on December 5, 2001, she was assessed as being at risk for the development of pressure sores.
- Despite this known risk, the nursing home failed to consistently and adequately turn and position Mrs. A. and failed to properly use appropriate pressure relieving devices — two of the most common and basic measures for preventing the development of pressure sores.
- Nursing staff also failed to monitor, assess and accurately document Mrs. A.'s general skin condition. As a result, pressure sores were not detected until they had reached an advanced stage.
- Between December 5, 2001, and February 1, 2002, Mrs. A. developed pressure sores on her sacrum* and left heel that progressed to the point where skin tissue died and needed to be debrided.*
- By February 18, 2002, Mrs. A. had seven pressure sores: one pressure sore on her sacrum, three on her left foot, two on her left ankle and one on the left heel.
- Mrs. A. received out-patient treatment for her pressure sores at a specialized wound care center until April 2002, when the nursing home informed Mrs. A.'s family that her wound care could be provided by its "in-house wound team." Unbeknownst to Mrs. A.'s family, this "team" turned out to be only one physical therapy assistant.

- Mrs. A.'s son soon noted that his mother was deteriorating while receiving care from this one assistant. Despite reassurances from the facility, he insisted that she return to the wound care center.
- On April 24, 2002, Mrs. A. was seen at the wound care center and found to have numerous pressure sores and to be suffering from fever, infection and malnutrition. Her doctor immediately admitted her to the hospital.
- The wounds on Mrs. A.'s left leg were so infected and gangrenous that her leg had to be amputated in order to save her life. She also had to undergo debridement of her sacral wound.

THE AFTER PICTURE



The human cost of neglect:

- Multiple pressure sores on left leg, including a Stage III* and Stage IV* pressure sore
- Severe pain from pressure sores
- Gangrene and osteomyelitis* in left leg sores
- Amputation of left leg

The financial cost of neglect:

- $43,083.49 (hospital expenses, wound care, doctor fees)

ANY CONSEQUENCES TO THE FACILITY?

- Did the survey agency fine the facility for this neglect?.....**No**
- What was the amount of fine actually paid?.....**$0**
- Did the survey agency deny payments for all new admissions of residents on Medicare/Medicaid?.....**No**
- Did the survey agency place the facility on state monitoring status?.....**No**
- Was the facility's license placed on probationary status or revoked for this neglect?.....**No**
- Was this neglect criminally prosecuted?.....**No**

Resident: Sidney G.
State: Florida
Type of Facility: Nursing Home
Residency: 10/21/97 – 11/21/98

THE BEFORE PICTURE

An introduction to Sidney G.

- Age: 69
- Life's occupation: Welder
- 2 children, 3 grandchildren, 3 great grandchildren
- Loved the beach
- Hard working family man

Facility assessment of Sidney G. upon admission:

- Dementia
- At high risk for falls
- History of wandering

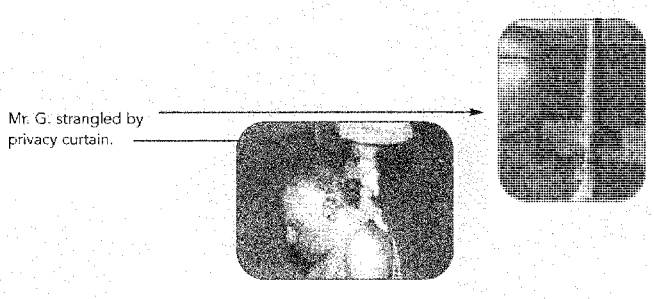
A PROFILE IN NEGLECT

How Sidney G. was neglected:

- Staff assessed Mr. G. as being at "high risk" of falls throughout his stay, which began in October 1997, yet failed to provide him with preventative fall measures such as a bed alarm, increased monitoring, or mats on the floor next to the bed.
- Mr. G. sustained 30 falls — a number the facility's Assistant Director of Nursing admitted was "excessive."
- In addition to his falls, Mr. G. experienced 8 injuries, including a skull fracture and cuts, that were not related to his documented falls and could not be explained by staff.
- On January 8, 1998, a nurse documented that Mr. G.'s shirt became "entangled in the bedside curtain which was tangled around his neck." Mr. G. could not dislodge himself. His shirt had to be cut off to release the tension around his neck.
- Following this incident, Mr. G.'s doctor wrote "will continue to observe patient closely to prevent such episodes in future."
- The Assistant Director of Nursing, who herself untangled Mr. G. twice, described what happened: "He would … grab the end of the curtain and just start twisting himself in it, twisting and twisting and turning and turning, turning, turning, turning until he was wrapped up in a curtain."
- The Assistant Activities Coordinator stated that she had untangled Mr. G. at least 6 times. She said that his entanglement "could happen at any time" and that it was a "dangerous or potentially dangerous condition."

- An aide testified that the fact that Mr. G. would get caught up in the bedside curtain was well known throughout the facility.
- Despite clear, widespread awareness of this hazard to Mr. G. and at least 8 incidents of entanglement, nursing staff failed to develop and carry out a plan of care to address this problem. They failed to implement even the most basic interventions, such as removing the cubicle curtain since Mr. G. was in a private room, moving Mr. G. to a room without a cubicle curtain, providing a safe partition or providing a tear-away curtain.
- Early in the morning on November 21, 1998, Mr. G. was found on the floor of his room with the "privacy curtain twisted in gown at the back of neck toward R [right] side.... The nurse wrote, "I checked the carotid* artery and there was no pulse."
- The autopsy report from the Broward County medical examiner stated that the cause of death was mechanical asphyxia* due to neck compression.

THE AFTER PICTURE



The human cost of neglect:

- Broken bones, including a fractured skull and depressed nasal bone fracture
- Multiple lacerations requiring sutures, bruises, skin tears, abrasions
- Strangulation
- Death

The financial cost of neglect:

- Unknown

ANY CONSEQUENCES TO THE FACILITY?

- Did the survey agency fine the facility for this neglect?.....No
- What was the amount of fine actually paid?.....$0
- Did the survey agency deny payments for all new admissions of residents on Medicare/Medicaid?.....No
- Did the survey agency place the facility on state monitoring status?.....No
- Was the facility's license placed on probationary status or revoked for this neglect?.....No
- Was this neglect criminally prosecuted?.....No

15

Resident: Angelo M.
State: Florida
Type of Facility: Nursing Home
Residency: 7/18/97 – 2/9/99

THE BEFORE PICTURE

An introduction to Angelo M.

- Age: 58
- Strong family ties
- Enjoyed drawing and singing

Facility assessment of Angelo M. upon admission:

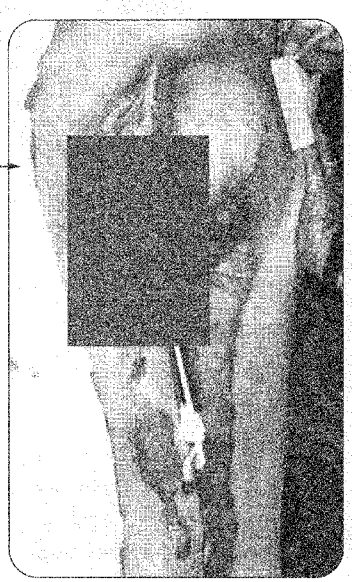
- Dementia
- History of schizophrenia, controlled with medication
- Malnutrition
- Partially dependent on staff for help with eating, toileting, dressing/grooming, walking and transferring*

A PROFILE IN NEGLECT

How Angelo M. was neglected:

- The nursing home to which Mr. M. was admitted on July 18, 1997, had a history of trouble with its hot water temperature.
- According to testimony from the facility's own maintenance director, the facility had experienced problems with fluctuating hot water temperature since 1990, temperatures had exceeded 140 degrees Fahrenheit on several occasions, and although he fixed the problem each time, it kept recurring.
- The maintenance director repeatedly reported the problem with the hot water temperature to both the Administrator and the Administrator's supervisor.
- Nursing staff were also aware of the hot water problem and had brought the issue to the attention of the Administrator. An aide stated under oath that water in the showers was excessively hot and that she had burnt her hands many times. She stated that she had reported the problem to her supervisor.
- Despite these reports from nursing home staff, facility management denied there was a problem and failed to fix the fluctuating hot water temperature.
- On May 5, 1998, Mr. M. was severely burned over his genital area and legs in a shower with water that exceeded 140 degrees Fahrenheit.
- An investigation conducted by the Florida Agency for Health Care Administration found that that nursing home had violated regulations by having excessively hot and dangerous water temperatures.

THE AFTER PICTURE



The human cost of neglect:

- Second degree burns over Mr. M.'s genital area and legs
- Pain so severe that morphine was prescribed for dressing changes
- According to Mr. M.'s treating physician, these second degree burns were more painful than third degree burns because the nerve ends were exposed
- Decreased ability to walk resulting from the burns

The financial cost of neglect:

- $8,200 (hospital expenses)

ANY CONSEQUENCES TO THE FACILITY?

- Did the survey agency fine the facility for this neglect?.....No
- What was the amount of fine actually paid?.....$0
- Did the survey agency deny payments for all new admissions of residents on Medicare/Medicaid?.....No
- Did the survey agency place the facility on state monitoring status?.....No
- Was the facility's license placed on probationary status or revoked for this neglect?.....No
- Was this neglect criminally prosecuted?.....No

16.

Resident: Ruth G.
State: Massachusetts
Type of Facility: Nursing Home
Residency: 4/13/99 – 1/14/02

THE BEFORE PICTURE

An introduction to Ruth G.

- Age: 80
- Life's occupation: Homemaker
- 3 children

Facility assessment of Ruth G. upon admission:

- At high risk for falls
- No pressure sores*
- Dementia
- Recovering from fractured right wrist from fall at home
- Anticipated return to home

A PROFILE IN NEGLECT

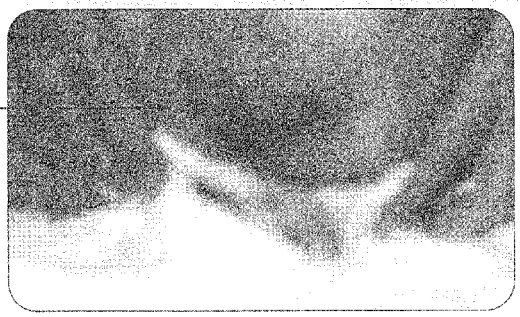
How Ruth G. was neglected:

- Following her admission to the facility in April 1999, Mrs. G. sustained multiple falls that left her bedridden and totally dependent on staff.
- Due to her lack of mobility, nursing staff assessed her in April 2001 as being at high risk of developing pressure sores.
- In November 2001, nursing staff documented that Mrs. G. was beginning to develop pressures sores. A blister was noted on her right heel on November 6, and a superficial open area was found on her right buttock on November 16, 2001.
- The nursing staff failed to provide adequate care and treatment for these pressure sores. Staff did not elevate Mrs. G.'s heels off the mattress to reduce pressure nor turn her routinely every two hours on all shifts. Furthermore, there is no indication that treatments ordered by the doctor were even carried out because treatment records were missing from Mrs. G.'s nursing home chart.
- Mrs. G.'s pressure sores worsened and became infected.
- Despite the development and progression of her sores, Mrs. G.'s care plan* was never changed in any way to include interventions or approaches to address this problem.
- The pressure sore on Mrs. G.'s right heel progressed to a Stage III* pressure sore with pus-

filled drainage by November 19, 2001. The skin on her left heel broke down and became a pressure sore by December 2001.

- The open area on Mrs. G.'s right buttock also worsened until it became a Stage IV* pressure sore which extended over the coccyx* with a large amount of drainage, a foul odor and tunneling* in December 2001. The pressure sore measured 4.5 cm x 3.5 cm with 2 cm tunneling.
- In order to treat this pressure sore, Mrs. G. had to go undergo debridement* on December 20, 2001.

THE AFTER PICTURE



Pressure sore on right buttock.

The human cost of neglect:

- Stage IV pressure sore on buttocks/coccyx
- Stage III pressure sore on right heel
- Pressure sore on left heel

The financial cost of neglect:

- Approximately $20,000

ANY CONSEQUENCES TO THE FACILITY?

- Did the survey agency fine the facility for this neglect?.....No

What was the amount of fine actually paid?.....$0

Did the survey agency deny payments for all new admissions of residents on Medicare/Medicaid?.....No

Did the survey agency place the facility on state monitoring status?.....No

Was the facility's license placed on probationary status or revoked for this neglect?.....No

Was this neglect criminally prosecuted?.....No

17.

Resident: Margaret R.
State: Massachusetts
Type of Facility: Nursing Home
Residency: 3/1/01 – 3/26/02

THE BEFORE PICTURE

An introduction to Margaret R.

- Age: 74
- Life's occupation: Homemaker
- Cared for brothers and sisters

Facility assessment of Margaret R. upon admission:

- Severe dementia
- At risk of dehydration
- Totally dependent on staff for help with drinking
- No pressure sores*
- At moderate risk of pressure sores
- No contractures*
- No end stage disease or terminal illness

A PROFILE IN NEGLECT

How Margaret R. was neglected:

- Upon Mrs. R.'s admission to the nursing home on March 1, 2001, it was determined that she needed staff to help her drink. Facility documentation also indicated that when provided with this assistance, Mrs. R. drank well. In fact, nursing staff stated in interviews with the Massachusetts Department of Public Health that Mrs. R. would "drink like a fish" when offered liquids.
- Because Mrs. R. was at risk of dehydration, the nursing home dietician assessed the amount of fluid that Mrs. R. needed to have each day. However, staff failed to provide her with the daily amount of fluids she was supposed to receive.
- Mrs. R. was hospitalized two times for dehydration. On September 13, 2001, she was admitted with a diagnosis of dehydration and had to be given two liters of intravenous fluid. Only two weeks later, on September 27, 2001, Mrs. R. was again hospitalized, this time with acute renal* failure related to dehydration.
- At the same time that she was suffering from dehydration, Mrs. R. began to develop pressure sores, starting with a Stage II* pressure sore on her right heel in September 2001.
- Over the next six months, the facility failed to provide the care Mrs. R. needed to prevent and treat pressures sores. As a result, the number and severity of her pressure sores grew.
- Nursing home records indicated pressure sores on both Mrs. R.'s heels in October 2001; Stage II pressure sores on both her buttocks and continued pressure sores on her heels in November 2001; and a new Stage II pressure sore on her coccyx* in December 2001.
- On December 25, 2001, a nurse documented that Mrs. R.'s coccyx sore was getting worse and that Mrs. R. needed to be seen by a doctor for an evaluation.

- Despite this documentation, nursing staff failed to have Mrs. R.'s physician examine the pressure sore until almost six weeks later on February 3, 2002.
- By February, the pressure sore on Mrs. R.'s coccyx had progressed to a Stage IV* sore and measured 10 cm x 10 cm x 4 cm with undermining* and a large amount of foul smelling drainage. Mrs. R. also had a 19 cm x 6 cm x 1 cm Stage III* pressure sore on her right leg and areas of eschar* on both heels and the left foot.
- Mrs. R. was admitted to the hospital for evaluation of her pressure sores on March 7, 2002. She was found to have a Stage IV pressure sore on her sacrum*/coccyx*; a Stage III pressure sore on the right heel, and two areas of eschar on her left heel. She also had a Stage IV pressure sore on her inner right leg that the physician said was caused by the left knee pressing into the right leg.
- A surgeon at the hospital documented that Mrs. R. had severe leg contractures. Not only had the facility failed to prevent the formation of these contractures, there was no documentation in the nursing home records to show that staff even knew that these contractures existed.
- A week later, Mrs. R. was sent to the hospital again where the doctor indicated that her left knee was so firmly pressed into the right leg that they could not be pried apart.
- Mrs. R. died of a stroke on March 26, 2002. According to one of her physicians, her right leg would have required amputation if she had lived.

THE AFTER PICTURE

Pressure sore on sacrum/coccyx.

The human cost of neglect:

- Dehydration requiring hospitalization
- Stage IV pressure sore on coccyx
- Stage IV pressure sore on right leg
- Pressure sores on both heels
- Severe leg contractures

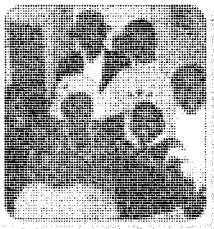
The financial cost of neglect:

- Approximately $287,000

ANY CONSEQUENCES TO THE FACILITY?

- Did the survey agency fine the facility for this neglect?.....**No**
- What was the amount of fine actually paid?.....**$0**
- Did the survey agency deny payments for all new admissions of residents on Medicare/Medicaid?.....**No**
- Did the survey agency place the facility on state monitoring status?.....**No**
- Was the facility's license placed on probationary status or revoked for this neglect?.....**No**
- Was this neglect criminally prosecuted?.....**No**

18.



Resident: Sylvena S.
State: Massachusetts
Type of Facility: Nursing Home
Residency: 9/8/00 – 9/20/01

THE BEFORE PICTURE

An introduction to Sylvena S.

- Age: 80
- Life's occupation: Homemaker

Facility assessment of Sylvena S. upon admission:

- Had suffered several strokes
- Confused
- At high risk for falls
- Peripheral vascular disease*
- Extensively dependent on staff for help with eating, toileting, dressing/grooming, walking, and transferring*

A PROFILE IN NEGLECT

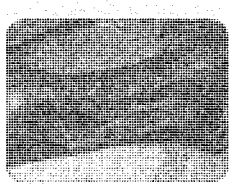
How Sylvena S. was neglected:

- Nursing home staff failed to adequately protect Mrs. S. from accidents and injury during her stay at the facility.
- On February 19, 2001, another resident at Mrs. S.'s nursing home was found lying in bed at 5 a.m. with her feet resting on the baseboard heater. The resident sustained burns to her toes. A nurse who treated the burns that morning said that the baseboard heater was very hot and "she could not have kept her fingers on it for more than 60 seconds." When checked after the incident, the temperature of the thermostat was found to be set at 90 degrees.
- Despite this incident, the nursing home failed to take adequate measures to prevent Mrs. S. from suffering the same injury the very next day, as she did.
- On February 20, 2001 at 7:30 a.m., Mrs. S.'s bed alarm sounded. Because Mrs. S. was at high risk of falls, her doctor had ordered this alarm to alert staff when she started to get out of bed unassisted.
- The nursing assistant who responded found Mrs. S. lying on her stomach, half out of the bed, with the tops of her feet and her shins resting on the baseboard heater. According to an expert physician, the nursing assistant did not respond quickly enough to the alarm.
- Two nurses stated to the Massachusetts Department of Public Health that they touched the baseboards and found them to be very hot. The temperature of the thermostat was not determined after the incident.
- Although the facility stated that it began rounds immediately after the first burn incident on February 19 to ensure that all beds were at a safe distance from the baseboard heaters, Mrs. S.'s bed was placed close enough to the heater on February 20 for her to be burned when she fell out of bed. In fact, Mrs. S.'s family measured the distance of their mother's bed from the heater and determined that the bed was closer than the distance required by state regulations.

- Mrs. S. received burns on the tops of both her feet and her left leg. She began to experience pain immediately, and according to a nurse who was called to the room by the nursing assistant, Mrs. S. complained of "burning" pain to both feet.
- Mrs. S. was not taken to the hospital for her burns until three months after the incident. The Wound Care Clinic at the hospital assessed her as having second and third degree burns that required debridement*.
- Even though Mrs. S.'s doctor ordered follow-up appointments at the Wound Care Clinic, the nursing home failed to take her to the clinic for two months.
- In the process of healing the burns on top of Mrs. S.'s feet, nursing staff failed to regularly and sufficiently elevate Mrs. S.'s heels. In addition, the facility did not provide or arrange for Mrs. S.'s transportation to Wound Care Clinic appointments. As a result, Mrs. S. developed pressure sores* on both her heels that were not properly treated.
- The pressure sore on Mrs. S.'s left foot became gangrenous*.
- Although her family moved her to another nursing home in September 2001 because they were concerned about care issues, it was too late to reverse the harm Mrs. S. had experienced. By November 13, 2001, the gangrene in her left foot had become so severe that the leg had to be amputated.
- According to an expert physician, the failures of the nursing home staff "were direct contributing factors to the left above knee amputation."

THE AFTER PICTURE

Burn on leg. →



The human cost of neglect:

- Pain from the burns
- Reduced mobility
- Contractures of lower extremities
- Gangrene
- Amputation of left leg

The financial cost of neglect:

- Approximately $180,000

ANY CONSEQUENCES TO THE FACILITY?

- Did the survey agency fine the facility for this neglect?.....**No**
- What was the amount of fine actually paid?.....**$0**
- Did the survey agency deny payments for all new admissions of residents on Medicare/Medicaid?.....**No**
- Did the survey agency place the facility on state monitoring status?.....**No**
- Was the facility's license placed on probationary status or revoked for this neglect?.....**No**
- Was this neglect criminally prosecuted?.....**No**

19.

Resident: Herbert H.
State: Pennsylvania
Type of Facility: Nursing Home
Residency: 4/17/01 – 10/31/01

THE BEFORE PICTURE

An introduction to Herbert H.

- Age: 76
- Life's occupation: Supervisor, U.S. Postal Service
- 2 children, 4 grandchildren
- Decorated U.S. Army veteran
- Loved to golf and bowl

Facility assessment of Herbert H. upon admission:

- Parkinson's Disease
- Dementia
- Swallowing difficulty
- Received nutrition via a feeding tube

A PROFILE IN NEGLECT

How Herbert H. was neglected:

- From May 19, 2001 through June 16, 2001, nursing staff documented that Mr. H. either pulled out his feeding tube or pulled at the tube and its dressing several times. On two occasions, the tube had to be reinserted at the hospital.
- Although Mr. H. had repeatedly pulled out his feeding tube, the facility failed to address this behavior or develop any interventions to prevent his removal of the feeding tube.
- At 4:30 p.m. on October 30, 2001, Mr. H. pulled out his feeding tube while in the shower. There was bleeding from the insertion site.
- Despite the fact that bleeding had occurred and that on two previous occasions his tube had required reinsertion at the hospital, the Director of Nursing reinserted the tube. The Director of Nursing documented that the reinsertion was "traumatic" because Mr. H. "stiffened" during the process.
- According to a Pennsylvania Department of Public Health investigation, the Director of Nursing did not verify the positioning of the tube in accordance with facility policy. As a result, she failed to recognize that she had in fact incorrectly placed the tube into the lining of Mr. H.'s stomach.
- Mr. H. continued to be fed via the misplaced feeding tube.
- Nursing staff did no further monitoring of Mr. H. until requested to do so at 8:00 p.m. by Mr.

H.'s family. According to the nurse's notes, Mr. H. was cold, moaning, crying out, grimacing and in pain. A large amount of blood had soaked through his dressing at the feeding tube site.

- The nurse stopped the tube feeding and administered Tylenol for pain via the feeding tube. There is no documentation to show that she verified the placement of the feeding tube or that she notified the doctor about Mr. H.'s change in condition.
- Nursing staff did not monitor or assess Mr. H. again until summoned for the second time by the family, who stated that Mr. H. was "all wet and clammy."
- The nurse observed that Mr. H. continued to cry out in pain and contacted the doctor, who prescribed Darvocet* for severe pain. The Darvocet was administered to Mr. H. via the feeding tube.
- By 10:30 p.m., Mr. H. was experiencing increased pain, and his abdomen was "tight." The nurse called the doctor, who then ordered that Mr. H. be sent to the hospital for evaluation of the feeding tube placement.
- Tests conducted at the hospital found that the Director of Nursing had reinserted the feeding tube incorrectly. As a result, the food and medications that nurses had given repeatedly via the feeding tube had gone into Mr. H.'s peritoneum*, rather than his stomach, causing peritonitis*.
- Mr. H. continued to suffer pain while at the hospital and died at 1:59 p.m. on October 31, 2001. The cause of death was listed as blood in the peritoneum due to perforation of the feeding tube tract.

The human cost of neglect:

- Horrific pain and suffering for over 21 hours
- Peritonitis
- Death

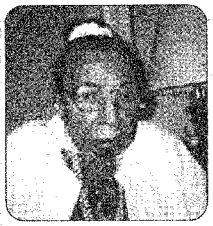
The financial cost of neglect:

- Unknown

ANY CONSEQUENCES TO THE FACILITY?

- Did the survey agency fine the facility for this neglect? **No**
- What was the amount of fine actually paid? **$0**
- Did the survey agency deny payments for all new admissions of residents on Medicare/Medicaid? **No**
- Did the survey agency place the facility on state monitoring status? **No**
- Was the facility's license placed on probationary status or revoked for this neglect? **No**
- Was this neglect criminally prosecuted? **No**
- Was action taken by the nurse licensing board? **No**

20.



Resident: Irene J.
State: Pennsylvania
Type of Facility: Nursing Home
Residency: 9/27/93 – present

THE BEFORE PICTURE

An introduction to Irene J.

- Age: 81
- Life's occupation: Teacher
- 1 son, 1 grandson

Facility assessment of Irene J. upon admission:

- Dementia
- Parkinson's Disease
- No contractures*
- No pressure sores*

A PROFILE IN NEGLECT

How Irene J. was neglected:

- From September 27, 1993, when Mrs. J. was admitted to the nursing home, to 2002, Mrs. J. lost weight and had a feeding tube inserted; her ability to walk deteriorated, resulting in immobility; and she became totally dependent on staff for all her needs.
- Mrs. J. was at risk of contractures once she could no longer walk. However, the facility failed to prevent the development and subsequent worsening of contractures of her knees and hips.
- By December 2001, Mrs. J.'s knees were severely contracted to an angle of 120 degrees.
- Beginning on January 8, 2002, Mrs. J.'s doctor ordered nursing staff to apply a wedge cushion behind Mrs. J.'s knees to prevent her legs from contracting further. The doctor also ordered that the wedge be removed for "hygiene and skin checks daily" and that nurses apply moisturizing cream to the back of Mrs. J.'s legs every day.
- Although nursing staff were ordered to examine and provide care to Mrs. J.'s legs every day, no one reported or documented a pressure sore behind Mrs. J.'s left knee until May 8, 2002, when it had become a Stage IV* pressure sore that was draining foul-smelling pus and so deep it went down to the bone. The pressure sore was found by an aide who, on that particular day, happened to be helping get residents ready for the day instead of carrying out her usual job of performing range of motion exercises with residents.
- The day the sore was discovered, Mrs. J. was sent to the hospital, where her pressure sore was examined and determined to be life-threatening. Her left leg was amputated above the knee.

- Despite being fed by tube, Mrs. J. was also found to be suffering from malnutrition.
- Mrs. J. suffered complications, including sepsis*, that were related to the pressure sore and amputation. She had to be hospitalized two additional times.
- The nursing home administrator admitted that the back of Mrs. J.'s knees had not been inspected.
- An expert physician stated, "In no fashion could acceptable bedside nursing care entail such superficial bathing, grooming and dressing that a to-the-bone pressure sore would go undetected until it was so severe as to necessitate amputation of the leg."

THE AFTER PICTURE

The human cost of neglect:

- Contractures
- Stage IV infected pressure sore
- Malnutrition
- Amputation of left leg
- Bleeding of stump
- Sepsis

The financial cost of neglect:

- $1,741 (hospital expenses)

ANY CONSEQUENCES TO THE FACILITY?

- Did the survey agency fine the facility for this neglect?.....**No**
- What was the amount of fine actually paid?.....**$0**
- Did the survey agency deny payments for all new admissions of residents on Medicare/Medicaid?.....**No**
- Did the survey agency place the facility on state monitoring status?.....**No**
- Was the facility's license placed on probationary status or revoked for this neglect?.....**No**
- Was this neglect criminally prosecuted?.....**No**
- Was action taken against the license of the nursing home administrator?.....**No**

21.

Resident: Angelita T.
State: Pennsylvania
Type of Facility: Assisted Living
Residency: 12/21/01 – 1/5/02

THE BEFORE PICTURE

An introduction to Angelita T.

- Age: 69
- Life's occupation: Homemaker
- 3 children, numerous grandchildren and great grandchildren
- Served as a foster mother

Facility assessment of Angelita T. upon admission:

- Alzheimer's Disease
- Confused and disoriented
- Able to walk with a cane

A PROFILE IN NEGLECT

How Angelita T. was neglected:

- Prior to her admission to the assisted living facility on December 21, 2001, Mrs. T. had a history of wandering from places where she lived, including her apartment and a nursing home.
- Mrs. T.'s daughter selected this particular facility because, in response to her concerns about her mother's propensity to wander, staff had assured her that they could provide proper supervision and care for her mother's needs.
- Although Mrs. T.'s daughter stressed that her mother was at risk of wandering from the facility, it was not recorded in Mrs. T.'s chart.
- The facility staff person who conducted Mrs. T.'s admission testified that residents had wandered from the facility in the past. Despite this problem, the employee stated that she was not directed to conduct an assessment of elopement* risk with new residents.
- A door alarm had been installed at the exits to the facility so that staff would be notified if residents left or attempted to leave the building. However, a facility employee testified that residents would disable the alarm from time to time and that facility administration knew this was happening.
- On January 5, 2002, Mrs. T.'s daughter arrived at the facility shortly after noon to visit. Her mother could not be found anywhere in the building. Staff had not noticed that Mrs. T. had wandered from the facility.
- A certified nursing assistant reported that she had seen Mrs. T. outside the facility. Although

the nursing assistant observed that Mrs. T. was unaccompanied, the assistant did not redirect Mrs. T. back to the facility, nor did she notify other staff until later.

- The police, fire department, facility staff and Mrs. T.'s family members searched for hours on January 5, but did not find her.
- Searches continued for weeks. During this time, the weather was cold, and there was snow on the ground.
- About three weeks later, on January 27, 2002, Mrs. T. was found dead, face down in a canal that was less than two miles from the facility. Her body was terribly decomposed.
- The coroner determined that Mrs. T. died of "hypothermia* with or without drowning."
- Because the decomposition of Mrs. T.'s body was so advanced, an open casket viewing could not be held. This deeply upset Mrs. T.'s family and caused them additional pain.

The human cost of neglect:

- Hypothermia
- Drowning
- Death

The financial cost of neglect:

- None

ANY CONSEQUENCES TO THE FACILITY?

- Did the survey agency fine the facility for this neglect?.....**No**
- What was the amount of fine actually paid?.....**$0**
- Did the survey agency deny payments for all new admissions of residents on Medicare/Medicaid?.....**Not applicable**
- Did the survey agency place the facility on state monitoring status?.....**No**
- Was the facility's license placed on probationary status or revoked for this neglect?.....**No**
- Was this neglect criminally prosecuted?.....**No**
- Was the certified nursing assistant listed as having committed an act of neglect on the state nurse aide registry?.....**No**

22

Resident: Germaine M.
State: Rhode Island
Type of Facility: Nursing Home
Residency: 9/14/00 – 2/29/04

THE BEFORE PICTURE

An introduction to Germaine M.

- Age: 87
- Life's occupation: Factory worker
- 2 children, 4 grandchildren, 2 great grandchildren
- Hosted square dance parties at her house

Facility assessment of Germaine M. upon admission:

- At risk for malnutrition
- Needed monitoring of food and fluids to ensure adequate intake
- Independent in eating, toileting, bathing, dressing/grooming, and transferring*
- Able to walk with a cane

A PROFILE IN NEGLECT

How Germaine M. was neglected:

- In late 2002, two years after Mrs. M. entered the nursing home, she fractured her left hip and subsequently experienced infection of her hip replacement. She became less mobile, which placed her at risk of pressure sores*.
- Mrs. M. developed a Stage I* pressure sore on her left buttock in August 2003.
- In December 2003, Rhode Island Department of Health surveyors observed that this sore had deteriorated to a Stage II* pressure sore and discovered two new Stage II* pressure sores — one on Mrs. M.'s coccyx* and one on her left lower buttock. The facility had been unaware of both of these new pressure sores.
- Nursing staff failed to follow doctor's orders for pressure relief of Mrs. M.'s heels and for a pillow to be placed under Mrs. M's legs.
- Mrs. M. was left lying in urine and stool without dressings in place on multiple occasions, which probably caused or contributed to an infection of the sores. On one occasion, nursing staff told the surveyors that they had been out of dressings for at least 3 days.
- By February 13, 2004, Mrs. M.'s left buttock pressure sore had worsened to a Stage IV* sore. State surveyors documented that dressings for Mrs. M.'s pressure sores were not changed or were improperly changed. One of the state surveyors later described Mrs. M.'s pressure sore, saying, "It's going through layers of skin. It's nine centimeters long, five wide, and three cen-

timeters deep. Deep, and it had a bloody discharge and large area of redness." The Department of Health determined that Mrs. M. was at immediate risk of serious injury or harm and ordered that she be moved to another unit that had less staff turnover.

- State surveyors found that nursing staff were not properly documenting Mrs. M.'s fluid intake and output and not providing her with the fluids she required.
- Based on a significant decline in Mrs. M.'s condition and care, the Rhode Island Department of Health ordered that she be moved to another facility on February 28, 2004.
- The facility where Mrs. M. had lived since September 2000 had a long history of poor pressure sore care. The Department of Health cited the nursing home for failure to prevent and treat pressure sores in December 2000; November 2001; October 2002; and yet again in November 2003.
- On June 6, 2004, the facility closed. A special report called for by the Rhode Island Governor states that the Department of Health (DOH) "should have taken more aggressive action to prevent further deterioration" of Mrs. M.'s condition after its survey on February 2, 2004. The report also notes that the "DOH should have moved more quickly to close admissions, to increase inspections, and based on the continued non-compliance, to close the facility."

The human cost of neglect:

- Stage IV pressure sore on buttocks
- Stage IV pressure sore on coccyx with tunneling* under the skin
- Pressure sore on heel
- Pain associated with pressure sore dressing changes

The financial cost of neglect:

- Unknown

ANY CONSEQUENCES TO THE FACILITY?

- Did the survey agency fine the facility for this neglect?.....**Yes**
- What was the amount of fine actually paid? .....**$0 as of 3/4/05 ($35,250 fine imposed)**
- Did the survey agency deny payments for all new admissions of residents on Medicare/Medicaid?.....**Yes**
- Did the survey agency place the facility on state monitoring status? .....**Yes**
- Was the facility's license placed on probationary status or revoked for this neglect?.....**No**
- Was this neglect criminally prosecuted? .....**Yes. There were 11 counts of neglect against the administrator.**
- Was action taken by the nursing home administrator licensing board?...**Yes. The license was revoked.**

23

Resident: John M.
State: Rhode Island
Type of Facility: Nursing Home
Residency: 8/1/02 – 3/28/03

THE BEFORE PICTURE

An introduction to John M.

- Age: 73
- Life's occupation: Machine Service Engineer
- 2 children, 5 grandchildren
- Played professional soccer in Scotland, his native country
- Lifetime member of the Masons

Facility assessment of John M. upon admission:

- Recovering from a stroke, with left side paralysis
- Had his larynx removed due to cancer of the larnyx
- Required occasional suctioning of tracheostomy tube*

A PROFILE IN NEGLECT

How John M. was neglected:

- As a result of the removal of his larynx more than a decade before his admission to the facility, Mr. M. breathed through a tracheostomy tube and was unable to speak. When he entered the nursing home on August 1, 2002, Mr. M. was using a voice enhancer, written messages and hand gestures to communicate.
- Mr. M.'s care plan* called for his tracheostomy tube to be suctioned as needed in order to clean away secretions that blocked his airway. Only licensed nurses can perform this task.
- Nursing staff had documented that this tube was Mr. M.'s "only method of breathing."
- On March 28, 2003, Nurse A., the registered nurse in charge of Mr. M.'s unit on the 3 p.m. – 11 p.m. shift, was a temporary employee sent in from an agency to fill in for the nurse who had originally been scheduled.
- Facility staff failed to properly orient Nurse A. to the needs of Mr. M. and his methods of communication.
- Shortly after going to bed on March 28, Mr. M. indicated to a nursing assistant that he needed to have his tracheostomy tube suctioned. The nursing assistant informed Nurse A.
- Nurse A. went to Mr. M.'s room and brought with him some tubing. However, the tubing was not the proper size, and Mr. M. refused to be suctioned with the wrong size tubing. Even though a suction machine with the proper size tubing was located beside Mr. M.'s bed, Nurse A. left the room without suctioning Mr. M.

- According to a nursing assistant in the room, Mr. M. gave her a note on which he had written, "Man came in to suction me with wrong tube. The place should be closed because the help is no good."
- Over the course of the next few hours, Mr. M. repeatedly tried to get help by banging on the rails of his bed. Two nursing assistants entered his room to investigate. One nursing assistant observed that Mr. M.'s tracheostomy tube looked "nasty."
- The nursing assistants who checked on Mr. M. informed Nurse A. that Mr. M. needed to be suctioned.
- Nurse A. repeatedly refused to suction Mr. M., stating, "He refused... What am I going to do?" Nurse A. did not return to Mr. M.'s room for the rest of the shift.
- Despite the condition of Mr. M.'s tracheostomy tube and his need for help, no nursing staff summoned help for Mr. M. from other facility nurses or from emergency personnel outside the facility.
- Nursing staff also failed to adequately monitor and supervise Mr. M. throughout the evening even though he was in clear distress. It was only on the 11 p.m. – 7 a.m. shift when nursing assistants were doing rounds that Mr. M. was found lying sideways across his bed with his legs hanging off the side. Mr. M. was cyanotic*; his respirations were about 2-4 per minute; and he had a large amount of blood tinged secretions coming from his tracheostomy site.
- A different nurse attempted to suction Mr. M., but to no avail. Mr. M. died shortly thereafter.
- Although the facility was required to report this incident to the Rhode Island Department of Health within 24 hours, it did not do so until seven days later.
- Even though the medical director of the nursing home knew that the facility staff were conducting an investigation of Mr. M.'s death, she reported on the death certificate that his death was the result of a stroke. Furthermore, without knowing the results of the facility's investigation, the medical director also stated on the death certificate that Mr. M.'s death was not related to an accident. The family only learned of the circumstances of Mr. M.'s death after his remains had been cremated.

The human cost of neglect:

- Death

The financial cost of neglect:

- None

ANY CONSEQUENCES TO THE FACILITY?

- Did the survey agency fine the facility for this neglect? ..... **No**
- What was the amount of fine actually paid? **$0**
- Did the survey agency deny payments for all new admissions of residents on Medicare/Medicaid? ..... **No**
- Did the survey agency place the facility on state monitoring status? ..... **No**
- Was the facility's license placed on probationary status or revoked for this neglect? ..... **No**
- Was this neglect criminally prosecuted? ..... **Yes. The nurse was prosecuted, pled no contest and received 3 years probation.**
- Was action taken by the nurse licensing board? ..... **Yes. The nurse was "reprimanded," but the license was not suspended or revoked.**

24

Resident: Alma R.
State: Rhode Island
Type of Facility: Nursing Home
Residency: 7/25/97 – 5/30/01

THE BEFORE PICTURE

An introduction to Alma R.

- Age: 86
- Life's occupation: Homemaker
- 2 children, 3 grandchildren

Facility assessment of Alma R. upon admission:

- Basal cell carcinoma* on face
- Early-stage dementia

A PROFILE IN NEGLECT

How Alma R. was neglected:

- In 1997, the same year that Mrs. R. was admitted to the nursing home, the facility hired Nurse C., a registered nurse.
- The nursing home failed to adequately screen Nurse C. prior to hiring her. Although a letter from the local police department indicated that the nurse's criminal background check revealed "information that would appear to disqualify this individual," neither the Administrator nor the Director of Nursing followed up with the police department to see what this disqualification meant. Instead, the Director of Nursing merely questioned Nurse C., who said she had had a problem with some bad checks, but that the matter had been resolved. The Director of Nursing documented, "I accepted this explanation."
- In fact, Nurse C. had been convicted of stealing morphine pills from a terminally ill cancer patient while working as a home health nurse and sentenced to 4 years probation. Her nursing license had been suspended for 9 months.
- Nurse C. was assigned to the night shift and was the only nurse on duty at night.
- Beginning in November 1998, memos written by the Director of Nursing stated that pain medications had been disappearing and narcotics in the emergency kit had been tampered with during the night shift. The memo indicated that this had been happening for a while.
- In 1999, a questionnaire completed by nursing staff noted medication discrepancies, including missing Demerol*, over the past year. In November 1999, the Director of Nursing documented that about 200 Darvocet* pills were missing and "issues with the E-kit" (emergency kit) were distressing her.
- By March 2000, nursing staff were reporting specific concerns about Nurse C.'s performance on the night shift to the Director of Nursing. Reports included incidents where staff had observed Nurse C. walking unsteadily, sleeping on the third shift, or appearing to be in "questionable condition." One member of the nursing staff noted a time when Nurse C. got on the elevator and

"the door just kept opening and closing and she just stared off as if in a daze." The Director of Nursing herself observed that Nurse C. "appeared to be drugged" on one occasion.

- Despite multiple concerns raised by nursing staff and ongoing problems with missing narcotics, the facility continued to employ Nurse C.
- Beginning in December 2000, Mrs. R.'s doctor ordered Oxyfast, a powerful narcotic painkiller that is effective in relieving severe pain.
- That same month, the Director of Nursing informed Nurse C. that she was suspicious that Nurse C. had been stealing the Oxyfast.
- The administrator and the Director of Nursing conducted an investigation into Nurse C.'s conduct. Their conclusion was: "documentation lacking – gross error in skills – too much can't tolerate can't risk." Despite these findings, Nurse C. was not fired; instead, she was placed on probation at the end of December for three months.
- Even when the Director of Nursing learned in January 2001 that Nurse C. had been convicted for stealing drugs and had lied about her past, Nurse C. was permitted to remain on staff with full privileges to run the facility, access the narcotics locker and dispense pain medication to residents.
- Two months later, on March 12, the Director of Nursing told Nurse C. that she had discovered Oxyfast that had been diluted with an unknown substance. The Director of Nursing reported the adulterated drug to the police, but still did not fire Nurse C.
- Nurse C. resigned three days later, was arrested, and pled no contest to three criminal counts of tampering with a controlled substance.
- Nurse C. admitted to the police that she had stolen Mrs. R.'s Oxyfast for two months.
- During this two-month period of time, Mrs. R. did not receive her prescribed, necessary painkiller for relief from the severe pain caused by her cancer that had invaded her sinuses and eye orbits. Two experts in pain management stated that as a result, Mrs. R. suffered increased pain.
- In a statement written by a police officer investigating the stolen medication, the officer stated that the Director of Nursing "informed me that she has suspected that Nurse C. has been taking or tampering with patients medications for about three years."

The human cost of neglect:

- Increased pain from cancer

The financial cost of neglect:

- None

ANY CONSEQUENCES TO THE FACILITY?

- Did the survey agency fine the facility for this neglect? **No**
- What was the amount of fine actually paid? **$0**
- Did the survey agency deny payments for all new admissions of residents on Medicare/Medicaid? **No**
- Did the survey agency place the facility on state monitoring status? **No**
- Was the facility's license placed on probationary status or revoked for this neglect? **No**
- Was this neglect criminally prosecuted? **Yes.**

The nurse's license was suspended indefinitely. No action was taken against the Director of Nursing.

25

Resident: Martha Doe†
State: Texas
Type of Facility: Nursing Home
Date of Investigation: 9/5/02

THE BEFORE PICTURE

An introduction to Martha Doe

- Age: 87

Facility assessment of Martha Doe upon admission:

- Dementia
- Unable to communicate
- Unable to walk
- Totally dependent on staff for help with eating, toileting, dressing/grooming, and transferring*

A PROFILE IN NEGLECT

How Martha Doe was neglected:

- Staff D, a male certified nursing assistant, was hired by the facility on January 31, 2000.
- Over the course of the next two years, three allegations of abuse were made against Staff D. These allegations involved hitting a resident's colostomy bag* three times and telling the resident to empty it; bruising a resident's wrist after saying he would "take care" of this resident when another staff person complained about the resident; and handling residents roughly and yelling at them.
- The administrator was aware of all three allegations, yet did not ensure that they were thoroughly investigated and failed to report these allegations to the Texas Department of Health, as required by law.
- Staff D was "counseled" regarding the alleged abuse on March 3, 2000, November 22, 2000, and again on August 1, 2002. However, he continued to have contact with residents.
- On September 4, 2002, facility staff discovered that Mrs. Doe was experiencing vaginal bleeding and had lacerations of her vaginal area.
- Mrs. Doe was admitted to the hospital and underwent a Sexual Abuse Forensic Examination (SAFE) that found vaginal tearing, severe genital trauma, sperm, multiple lacerations, avulsions*, and abrasions. The results of the examination revealed that Mrs. Doe had been raped.

† Fictitious name because information was taken from a Texas Department of Health inspection report in which the resident is unnamed.

- Mrs. Doe returned to the facility at 1:30 a.m. on September 5, 2002.
- Even though facility staff had been informed that Mrs. Doe had injuries "indicative of sexual assault," they did not implement any protective measures to prevent Mrs. Doe or other residents from further sexual abuse.
- Despite suspicions that Staff D was the perpetrator, the facility failed to prevent him from contact with vulnerable residents during the course of its investigation of the allegation.
- Staff D confessed to the police that he had committed the sexual assault.
- After investigating the rape, the Texas Department of Health determined that the nursing home had failed to develop a facility-wide system to protect residents and that this failure contributed to the sexual abuse.

The human cost of neglect:

- Rape
- Vaginal tearing
- Severe genital trauma
- Avulsions*
- Abrasions

The financial cost of neglect:

- Unknown

ANY CONSEQUENCES TO THE FACILITY?

- Did the survey agency fine the facility for this neglect? ..... **Yes**
- What was the amount of fine actually paid? ..... **$67,500. Federal fine also imposed — amount paid unknown.**
- Did the survey agency deny payments for all new admissions of residents on Medicare/Medicaid? ..... **Yes**
- Did the survey agency place the facility on state monitoring status? ..... **No**
- Was the facility's license placed on probationary status or revoked for this neglect? ..... **Unknown**
- Was this neglect criminally prosecuted? ..... **Unknown**

26.

Resident: Myrtle G.
State: Texas
Type of Facility: Nursing Home
Residency: 9/17/97 – 1/21/98

THE BEFORE PICTURE

An introduction to Myrtle G.

- Age: 90
- Life's occupation: Nursing home dietary employee

Facility assessment of Myrtle G. upon admission:

- Left hip fracture
- Diabetes
- Receiving food and fluids through a feeding tube
- No pressure sores*
- No pain symptoms
- No end-stage disease

A PROFILE IN NEGLECT

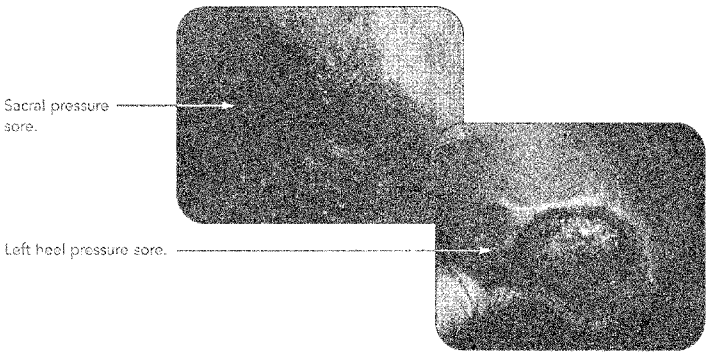
How Myrtle G. was neglected:

- Nursing staff persistently failed to give Mrs. G. the fluids she required via her feeding tube. According to her attending physician, "Myrtle became dehydrated due to the fact that the nursing home provided less than one third of her fluid needs."
- Nursing staff also persistently failed to give Mrs. G. the nutrition she needed through tube feeding as ordered. Mrs. G. lost 26 lbs over 4 months.
- Nursing staff routinely violated physician's orders to turn and reposition Mrs. G., resulting in the formation of two severe pressure sores.
- Mrs. G. developed a Stage IV* pressure sore on her sacrum*, measuring 7.5 cm x 5 cm, which was severely infected and necrotic*. This sore was not documented or treated by the nursing home at all.
- Mrs. G. developed a Stage IV, infected, necrotic left heel pressure sore which penetrated to the bone, encompassing the entire heel. The sore led to osteomyelitis*.
- Nursing staff repeatedly failed to notify Mrs. G.'s physician of significant changes in Mrs. G.'s skin, weight and hydration status.
- Mrs. G.'s attending physician testified: "The nursing home never informed me of the deteri-

oration of her wounds," and "The facility never notified me that Myrtle was septic* in appearance."

- Mrs. G. experienced excruciating pain as a result of her pressure sores, eventually requiring morphine to get relief. However, nursing staff continually failed to provide Mrs. G. with the medication she needed to relieve her suffering.
- Mrs. G. died on January 21, 1998, as a result of infection from her pressure sores.

THE AFTER PICTURE



The human cost of neglect:

- Two severe Stage IV pressure sores
- Malnutrition
- Dehydration
- Osteomyelitis
- Extreme pain from pressure sores
- Death

The financial cost of neglect:

- $13,058 (hospital expenses)

ANY CONSEQUENCES TO THE FACILITY?

- Did the survey agency fine the facility for this neglect?.....No
- What was the amount of fine actually paid? $0
- Did the survey agency deny payments for all new admissions of residents on Medicare/Medicaid? .....No
- Did the survey agency place the facility on state monitoring status?.....No
- Was the facility's license placed on probationary status or revoked for this neglect? .....No
- Was this neglect criminally prosecuted? .....No

27.

Resident: Jose M.
State: Texas
Type of Facility: Nursing Home
Residency: 6/17/98 – 11/27/01

THE BEFORE PICTURE

An introduction to Jose M.

- Age: 74
- Life's occupation: Restaurant worker

Facility assessment of Jose M. upon admission:

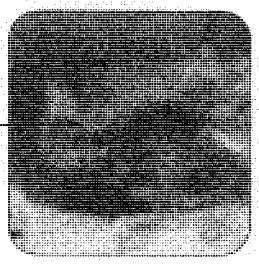
- Both legs amputated above the knee
- Diabetes
- Paralyzed on left side due to a stroke
- No pressure sores*
- No malnutrition
- No end-stage disease

A PROFILE IN NEGLECT

How Jose M. was neglected:

- Nursing staff repeatedly failed to assess and monitor the condition of Mr. M.'s skin to watch for the appearance of pressure sores. Nursing staff also failed to turn and reposition him to prevent the formation of pressure sores.
- As a result, Mr. M. developed an infected Stage IV* pressure sore on his tailbone measuring 12 cm in diameter and 2.4 cm deep, with exposed bone as well as multiple Stage II* and Stage III* pressure sores.
- As these sores developed, nursing staff failed to follow Mr. M.'s physician's orders for pressure sore treatment and for pain medication to alleviate the pain he suffered from the sores.
- In addition to their failure to provide Mr. M. with appropriate care for pressure sores, nursing staff also failed to monitor Mr. M.'s fluid intake and output. Mr. M. was hospitalized four times for dehydration. During one of the hospitalizations, the hospital discovered that Mr. M. had a 10-liter fluid deficit upon admission.
- Finally, despite his losing a significant amount of weight and having to have a feeding tube inserted, nursing staff repeatedly failed to monitor Mr. M.'s weight. On two occasions he lost 19 lbs. in 1 month.

THE AFTER PICTURE



Pressure sore on coccyx.

The human cost of neglect:

- Severe pressure sores, including a Stage IV sore with exposed bone
- Malnutrition
- Dehydration
- Extreme pain from pressure sores

The financial cost of neglect:

- $53,151 (hospital expenses)

ANY CONSEQUENCES TO THE FACILITY?

- Did the survey agency fine the facility for this neglect? ..... **No**
- What was the amount of fine actually paid? **$0**
- Did the survey agency deny payments for all new admissions of residents on Medicare/Medicaid? ..... **No**
- Did the survey agency place the facility on state monitoring status? ..... **No**
- Was the facility's license placed on probationary status or revoked for this neglect? ..... **No**
- Was this neglect criminally prosecuted? ..... **No**

28

Resident: Enid C.
State: Washington
Type of Facility: Nursing Home
Residency: 2/25/2000 – 1/19/2001

THE BEFORE PICTURE

An introduction to Enid C.

- Age: 91
- Life's occupation: Homemaker
- Married for 60+ years
- Enjoyed snowshoeing, traveling, playing cards, and swimming
- Had been very healthy – had not received any medical treatment for ten years prior to stroke

Facility assessment of Enid C. upon admission:

- Unable to speak or swallow following a stroke
- Little or no ability to move
- Totally dependent on staff for help with nutrition, dressing/grooming, transferring* and moving

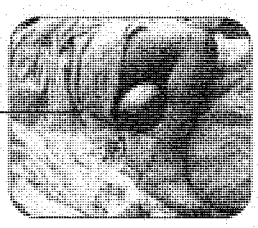
A PROFILE IN NEGLECT

How Enid C. was neglected:

- Mrs. C. was admitted to the facility February 25, 2000, after a stroke. In the first four months after admission to the facility, she improved mentally and physically. She was able to converse coherently and had been weaned off her feeding tube.
- In June 2000, Mrs. C. suffered a spiral (twisting) left femur fracture and subsequently a compounding/displacement of that fracture that broke through her skin above the knee and resulted in amputation of her leg above the knee.
- At the trial, an orthopedic expert testified that Mrs. C.'s spiral femur fracture was due to a twisting or rotational mechanism and that it would not be possible for Mrs. C.'s leg to fracture spirally by simply sneezing or rolling over in bed. He testified that the only two ways a spiral fracture of the kind sustained by Mrs. C. could have occurred would have been for someone to catch her legs in the bed rails and jerk her very hard, or drop her on the floor with Mrs. C. landing on her left leg, meaning that abuse or mistreatment was the likely cause.
- A Washington State Department of Social and Health Services (DSHS) investigation concluded that the facility did not conduct a thorough investigation into how the spiral fracture of Mrs. C.'s left femur occurred. No interviews of pertinent caregivers or witnesses were conducted by the facility in order to rule out abuse.

- In September 2000, while Mrs. C. was recovering from her leg amputation, one of her caregivers placed her in a wheelchair but left the armrest off. As a result, Mrs. C. fell out of her wheelchair and broke her neck. Due to her compromised condition, her physician ruled out surgery to repair her neck and she was fitted with a cervical collar to stabilize her neck.
- The use of the cervical collar caused multiple skin breakdowns on the back of her neck and on her chin. The ulcerations were so significant that they went to the bone on Mrs. C's chin.
- Due to the restrictive nature of the collar, Mrs. C. aspirated* and developed pneumonia.
- Mrs. C.'s family transferred her to another nursing home in January 2001, after concluding that the multiple problems of the past seven months raised too many concerns about the facility's competence.
- Mrs. C. died of pneumonia on April 23, 2001, after suffering many months of excruciating pain from her injuries.

THE AFTER PICTURE



The human cost of neglect:

- Broken femur
- Amputation
- Pressure sores*
- Broken neck
- Excruciating pain: a pathologist testified that the pain resulting from Mrs. C.'s displacement/compounding of the femur facture, which resulted in the bone poking through her skin above the knee, was "top floor"
- Death

The financial cost of neglect:

- Approximately $43,400 (hospital expenses)

ANY CONSEQUENCES TO THE FACILITY?

- Did the survey agency fine the facility for this neglect?.....**No**
- What was the amount of fine actually paid?.....**$0**
- Did the survey agency deny payments for all new admissions of residents on Medicare/Medicaid?.....**Yes**
- Did the survey agency place the facility on state monitoring status?.....**Yes**
- Was the facility's license placed on probationary status or revoked for this neglect?.....**No**
- Was this neglect criminally prosecuted?.....**No**

29

Resident: Dayl J.
State: Washington
Type of Facility: Nursing Home
Residency: 10/1994 – 5/10/1997

THE BEFORE PICTURE

An introduction to Dayl J.

- Age: 83
- Life's occupation: Home builder
- Married for 60 years
- Enjoyed attending Bible meetings and church
- Master gardener

Facility assessment of Dayl J. upon admission:

- Brain damage due to lack of oxygen
- Short-term memory problems

A PROFILE IN NEGLECT

How Dayl J. was neglected:

- During the final three weeks of Mr. J.'s life, he suffered three very serious choking incidents, the last of which ended his life.
- On April 15, 1997, Mr. J. choked and was saved by staff who administered the Heimlich maneuver to dislodge food blocking Mr. J.'s airway.
- After this incident, "alert charting" was ordered for Mr. J., meaning that nursing staff were to maintain acute, ongoing assessments and chart accordingly. Staff also identified Mr. J. as a resident with a "choking hazard while eating."
- Contrary to this order, nursing staff failed to chart anything in the progress notes for nearly two full days after this first incident.
- Less than 72 hours later, Mr. J. suffered another very serious choking incident while eating. Staff called 911 for paramedic assistance.
- After the second episode, staff were instructed to monitor Mr. J. at all meals and snacks, observe him for choking episodes, and ensure that Mr. J. had his dentures in while eating.
- A speech therapist who performed a swallow evaluation on Mr. J. on April 21, 1997, indicated that Mr. James must be supervised at all meals, that staff should ensure dentures are in for all meals, and that his "poor fitting dentures be realigned ASAP."
- A nurse concluded that public assistance would not pay for denture realignment again for another 18 months, so the realignment would not be done.

- On the evening of May 10, 1997, Mr. J. asked a nursing assistant for a snack and was given a peanut butter sandwich. Eating peanut butter sandwiches is very dangerous for people with swallowing difficulties. Mr. J. was not wearing his dentures.
- Failing to follow the doctor's orders that Mr. J. be monitored while eating, the nursing assistant left his room and walked down the hall. Meanwhile, Mr. J. choked on the sandwich, was unable to summon anyone to help him, and died.

The human cost of neglect:

- Suffocation by choking
- Death

The financial cost of neglect:

- None

ANY CONSEQUENCES TO THE FACILITY?

- Did the survey agency fine the facility for this neglect? ..... **Yes**
- What was the amount of fine actually paid? **$3,000**
- Did the survey agency deny payments for all new admissions of residents on Medicare/Medicaid? ..... **Information unavailable**
- Did the survey agency place the facility on state monitoring status? ..... **Information unavailable**
- Was the facility's license placed on probationary status or revoked for this neglect? ..... **Information unavailable**
- Was this neglect criminally prosecuted? ..... **No**

30.

Resident: Sandra S.
State: Washington
Type of Facility: Nursing Home
Residency: 9/24/98 – 8/9/02

THE BEFORE PICTURE

An introduction to Sandra S.

- Age: 58
- Life's occupation: Registered nurse
- Two daughters
- Played the piano at her church

Facility assessment of Sandra S. upon admission:

- Left side paralysis following a stroke
- Cognitive impairment
- No contractures*
- Teeth in "good" condition – no cavities or gum disease
- Totally dependent on staff for help with toileting, dressing/grooming, eating and transferring*

A PROFILE IN NEGLECT

How Sandra S. was neglected:

- The hospital physician attending to Mrs. S. when she suffered her stroke declared: "When Mrs. S. was discharged to the nursing home in September 1998, she was at risk for developing contractures. She should have received daily skilled physical therapy to prevent the onset of contractures."
- Mrs. S. was admitted to the nursing home in September 1998 because of her extensive need for assistance after being partially paralyzed by a stroke. The facility did not provide Mrs. S. with physical therapy or range of motion exercises. As a result, Mrs. S. developed painful contractures in her left arm/hand, left leg and right leg.
- Because the facility continued to fail to provide Mrs. S. with range of motion* exercises to prevent contractures throughout her four year stay, the contractures were allowed to progress.
- Eventually, Mrs. S.'s untrimmed fingernails grew into the palm of her left hand. Her left arm slowly contorted until it irreversibly twisted like a pretzel to her chest. Mrs. S.'s left leg painfully contracted over time until her foot ended up fixed underneath her knee. As a result, her knee developed a Stage IV* pressure sore.
- Mrs. S. was admitted to the hospital in May 2000. The hospital physician stated: "I have cared for about 600 stroke patients in the past ten years.....I was horrified and disturbed by her condition. I have never seen such severe contractures in my practice of medicine."
- In June 2000, Mrs. S.'s left arm had to be amputated at the shoulder because it had become so painfully contracted.

- After the amputation of her arm, Mrs. S. returned to the nursing home and the neglect continued.
- Mrs. S.'s oral hygiene was neglected so completely that in November 2001, all of her teeth had to be pulled as a result of rampant rot.
- In August 2002, Mrs. S.'s left leg had to be amputated above the knee because it had become painfully contracted and was causing a severe pressure sore. Her right hamstring was surgically cut to release the tension.
- Regarding conditions at the facility, a facility nurse testified: "the physical condition of the building was in disrepair and it stank of urine and feces… Most residents had food stuck on their teeth, their breath smelled like their teeth had not been brushed in a long time, their bodies stank because they had not been bathed, and incontinent residents were wearing or lying on soiled pads." She also testified that the restorative care* program was "non-existent."
- Another nurse testified: "To be blunt, and I am not overstating this, the facility was in chaos from the top down. I found a pervasive and long-standing pattern of delivering substandard care to its residents."
- The facility received over 100 citations from the state for violations of the minimum standards of care during Mrs. S.'s nearly four year stay.

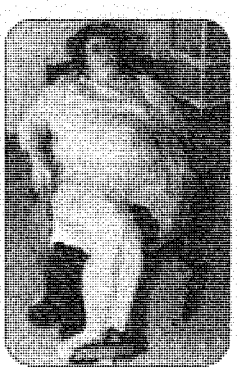
THE AFTER PICTURE

The human cost of neglect:

- Excruciating pain from contractures
- Severe pressure sore
- Amputation of left arm
- Amputation of left leg
- Loss of all teeth due to rot

The financial cost of neglect:

- Unknown



ANY CONSEQUENCES TO THE FACILITY?

- Did the survey agency fine the facility for this neglect? ..... **Yes**
- What was the amount of fine actually paid? **$3,000**
- Did the survey agency deny payments for all new admissions of residents on Medicare/Medicaid? ..... **Yes**
- Did the survey agency place the facility on state monitoring status? ..... **No**
- Was the facility's license placed on probationary status or revoked for this neglect? ..... **No**
- Was this neglect criminally prosecuted? ..... **No**
- Was action taken by the nursing home administrator licensing board? ..... **No**
- Was action taken by the physician licensing board? ..... **No**

31

Resident: Margaret D.
State: West Virginia
Type of Facility: Assisted Living
Residency: 8/24/98 – 9/30/99

THE BEFORE PICTURE

An introduction to Margaret D.

- Age: 78
- Life's occupation: Homemaker
- 2 children
- Enjoyed sewing

Facility assessment of Margaret D. upon admission:

- Alzheimer's Disease
- Had had a stroke

A PROFILE IN NEGLECT

How Margaret D. was neglected:

- Because of her Alzheimer's Disease and increased wandering away from home, Mrs. D's family felt that they could no longer care for her safely at home and admitted her to the facility on August 24, 1998. Mrs. D's family discussed her wandering with facility staff, and they assured Mrs. D's family that they were equipped to care for her and keep her safe.
- Subsequent to her admission, Mrs. D's cognitive and physical abilities deteriorated. Mrs. D's wandering and elopement* behaviors and frequent falls put her at high risk.
- From the time of her admission until the time of her death, Mrs. D. left the facility without notice by facility staff on 15 occasions. On one occasion, Mrs. D. was shocked by an electric fence while wandering from the facility.
- During her stay at the facility, Mrs. D. also experienced more than 22 falls. Several of the falls resulted in injury, including skin tears, bruises, scratches, and displacement of teeth.
- Despite these ongoing risks to her safety, the facility failed to effectively implement care and treatment plans to address Mrs. D's behaviors and conditions, such as bed or chair sensors, a Wanderguard bracelet, involvement in planned group activities, or relocation to a room where visual supervision was readily available.
- The facility also failed to determine that it could not effectively care for Mrs. D. and seek alternative placement to a facility with a contained living unit for residents for whom elopement is a risk.
- Unsupervised by staff, Mrs. D wandered from the facility again on September 30, 1999. At 6:45 p.m., she was found outside of the facility on the roadway, unresponsive, and with head injuries. She died of her injuries a few hours later at the hospital.

The human cost of neglect:

- Multiple injuries from falls
- Death

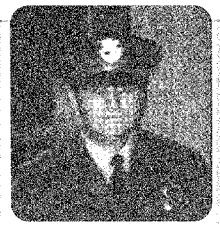
The financial cost of neglect:

- Unknown

ANY CONSEQUENCES TO THE FACILITY?

- Did the survey agency fine the facility for this neglect?.....No
- What was the amount of fine actually paid?.....$0
- Did the survey agency deny payments for all new admissions of residents on Medicare/Medicaid?.....Not applicable
- Did the survey agency place the facility on state monitoring status?.....No
- Was the facility's license placed on probationary status or revoked for this neglect?.....No
- Was this neglect criminally prosecuted?.....No

32



Resident: Jackie Lee H.
State: West Virginia
Type of Facility: Nursing Home
Residency: 12/11/1998 – 8/20/2002

THE BEFORE PICTURE

An introduction to Jackie Lee H.

- Age: 60 years old
- Life's occupation: Security guard
- 2 children

Facility assessment of Jackie Lee H. upon admission:

- Paralysis on one side of his body following a stroke
- No contractures*
- No pressure sores*
- Peripheral vascular disease*
- Totally dependent on staff for help with eating, toileting, dressing/grooming, and moving

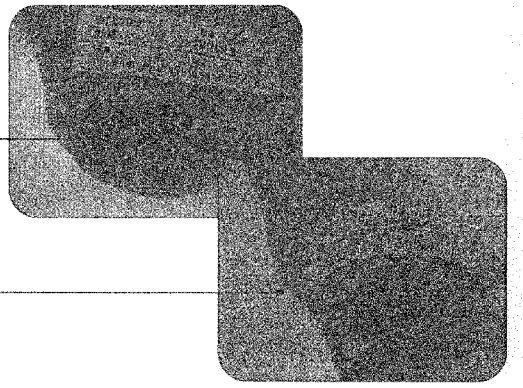
A PROFILE IN NEGLECT

How Jackie Lee H. was neglected:

- During his stay at the facility, Mr. H. developed ten pressure sores because facility staff failed to turn and reposition him every two hours.
- Mr. H. began to develop a pressure sore on his sacrum* on January 13, 2002.
- Upon his admission to the hospital on August 8, 2002, the pressure sore on Mr. H.'s sacrum had progressed to a Stage IV* sore measuring 6 cm in diameter and 2 cm deep.
- The facility failed to provide Mr. H. with range of motion* exercises, despite standing physician orders for restorative care as needed. As a result, Mr. H. developed contractures in both his arms and legs.
- A medical expert testified: "The facility had a duty to provide adequate treatment and services to maintain Mr. H.'s range of motion and to prevent further loss of range of motion, but this was not done. The loss of range of motion experienced by Mr. H. resulted from a breach in the standard of care for the prevention and treatment of contractures."
- Mr. H.'s contractures contributed to the development of additional pressure sores and to the amputation of both of his legs above the knee.

- The facility also failed to adequately manage Mr. H.'s pain. He regularly experienced extreme pain in his lower extremities. He frequently was heard calling out in pain.
- Mr. H.'s pressure sores became infected. The infection developed into septicemia*. He was transferred to the hospital for treatment on August 20, 2002, but the infection caused his death on August 21, 2002.

THE AFTER PICTURE



The human cost of neglect:

- Stage IV pressure sore on the sacrum
- At least nine other pressure sores
- Severe contractures of arms and legs
- Osteomyelitis*
- Amputation of both legs
- Extreme pain in lower extremities
- Septicemia*
- Death

The financial cost of neglect:

- Approximately $25,000 (hospital expenses)

ANY CONSEQUENCES TO THE FACILITY?

- Did the survey agency fine the facility for this neglect?.....**No**
- What was the amount of fine actually paid?.....**$0**
- Did the survey agency deny payments for all new admissions of residents on Medicare/Medicaid?.....**No**
- Did the survey agency place the facility on state monitoring status?.....**No**
- Was the facility's license placed on probationary status or revoked for this neglect?.....**No**
- Was this neglect criminally prosecuted?.....**No**

33

Resident: George R.
State: West Virginia
Type of Facility: Nursing Home
Residency: 5/5/01 – 12/20/02

THE BEFORE PICTURE

An introduction to George R.

- Age: 72
- Life's occupation: Construction worker
- 9 children

Facility assessment of George R. upon admission:

- Dementia
- Previous history of seizure disorder
- At high risk for pressure sores
- Able to walk

A PROFILE IN NEGLECT

How George R. was neglected:

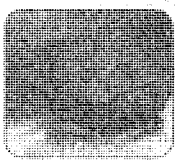
- Mr. R. was admitted to the nursing home in May 2001.
- Between May and August 2001, Mr. R. suffered severe weight loss – 8.9% of his body weight. Alternate methods of nutrition were not discussed with Mr. R.'s daughter until September 28, 2001, at which time she gave permission for insertion of a feeding tube pending approval of the physician.
- The nursing home did not discuss insertion of the feeding tube with the physician until April 30, 2002 – seven months after his family gave permission for tube insertion.
- After a brief hospitalization in September 2001, Mr. R. returned to the facility.
- Upon return to the nursing home, Mr. R. was totally dependent on nursing home staff for all basic care needs, and had blisters on both heels and a red area on his coccyx*.
- Despite noting these changes in his skin condition, nursing staff did not contact the doctor to obtain orders for wound treatments or pressure relieving devices for Mr. R.'s bed or chair.
- In October 2001, a pressure relieving mattress for Mr. R. was ordered but never placed on his bed.
- Between October 2001 and December 2002, Mr. R. developed at least 21 serious pressures sores*, progressing to Stage III* and IV*. Most of the sores became infected, and some sores resulted in osteomyelitis*.
- Although Mr. R. was continent of bladder and bowel upon admission, the facility did nothing to help him maintain his continence, such as assisting him with using the bathroom or implementing a toileting schedule for him. An assessment conducted on August 6, 2001, noted that Mr. R. was continent, yet he was put in diapers (which discourages residents from maintaining continence).

- Records reveal that Mr. R. needed some direction with toileting, but there was no indication that proper direction or a toileting schedule was provided. As a result, Mr. R. became totally incontinent of bowel.
- When Mr. R. had a foley catheter* inserted, nursing home staff often failed to provide basic cleaning of the catheter. As a result, Mr. R. suffered from multiple urinary tract infections during his stay at the facility.
- Mr. R. was often left sitting or lying in his own feces. This lack of hygiene contributed to the severe infection of his pressure sores. As shown by positive cultures of the wounds, most of the pressure sore infections resulted from cross contamination with urine and feces.
- When Mr. R. was diagnosed with a Methacillin Resistant Staphylococcus Aureus (MRSA)* infection in his pressure sores, nursing staff failed to implement MRSA precautions, which are required to prevent the spread of infection through the resident's body, and to prevent staff from infecting other residents.
- Mr. R.'s mobility declined due to the pain caused by his pressure sores.
- Nursing home staff then failed to provide Mr. R. with range of motion* exercises to maintain muscle tone and function, causing severe muscle wasting and joint contractures* to both his upper and lower extremities.
- By May 2, 2002, Mr. R.'s weight had plummeted to 118 lbs., a weight loss of 38% in one year.
- Mr. R. died in December 2002 while suffering extreme pain from numerous infected pressure sores and disfiguring and painful joint contractures.

THE AFTER PICTURE

Pressure sore on heel and feet. →

Pressure sore → on heel.



The human cost of neglect:

- 21 severe pressure sores
- Osteomyelitis*
- Methicillin Resistant Staphylococcus Aureus (MRSA) infection
- Multiple urinary tract infections
- Disfiguring contractures of all extremities
- Extreme pain from pressure sores and contractures

The financial cost of neglect:

- $105,224 (hospital expenses)

ANY CONSEQUENCES TO THE FACILITY?

- Did the survey agency fine the facility for this neglect?.....**No**
- What was the amount of fine actually paid?.....**$0**
- Did the survey agency deny payments for all new admissions of residents on Medicare/Medicaid?.....**Unknown**
- Did the survey agency place the facility on state monitoring status?.....**Unknown**
- Was the facility's license placed on probationary status or revoked for this neglect?.....**No**
- Was this neglect criminally prosecuted?.....**No**

34

Resident: Ralph B.
State: Wisconsin
Type of Facility: Nursing Home
Residency: 5/19/00 – 8/2/01

THE BEFORE PICTURE

An introduction to Ralph B.

- Age: 68
- Life's occupation: Machinist, security guard, mechanic
- 3 children, 2 grandchildren

Facility assessment of Ralph B. upon admission:

- Degenerative joint disease
- Wheelchair bound
- Partially dependent on staff for help with bathing and dressing/grooming
- Able to feed himself
- Alert and oriented
- Continent
- No end-stage disease or terminal illness

A PROFILE IN NEGLECT

How Ralph B. was neglected:

- After his admission to the facility on May 19, 2000, Mr. B. showed signs and symptoms of an upper respiratory infection in December 2000. He was immediately taken to see his doctor, who prescribed antibiotics. Mr. B. recovered.
- Several months later, on July 20, 2001, nursing staff documented that Mr. B. was again exhibiting the signs and symptoms of an upper respiratory infection. This time, however, they did not contact his doctor right away as they had done before.
- Nursing staff did not provide Mr. B. with extra fluids which the body needs when suffering from upper respiratory ailments.
- Mr. B.'s condition worsened over the next five to six days. Nurses documented that he became weaker, was not feeding himself, had a temperature of 100.6 degrees and could not hold himself up straight.
- By July 25, 2001, Mr. B.'s health had deteriorated so significantly that the nurse contacted his attending physician for new orders. Mr. B's physician was not available, but the on-call doctor ordered staff to do an immediate urine analysis, push fluids and have Mr. B. see his own doctor the very next morning.
- The results of the urine analysis taken on July 25 showed that Mr. B. was dehydrated.
- Contrary to the on-call doctor's order, Mr. B. was not taken to see his attending physician on

the morning of July 26.

- Over the next eight days, nursing staff did not push fluids as the doctor had ordered, and both Mr. B.'s dehydration and upper respiratory infection worsened. Later at the hospital it would be determined that Mr. B. had developed pneumonia that went untreated.
- Nurses documented a dramatic change in Mr. B.'s condition. He went from sitting up in his wheelchair and being continent, alert, oriented and able to feed himself, to being incontinent, exhibiting increased weakness to the point where he was "lying over the side of the wheelchair all the time," and "having trouble even sucking liquids through a straw."
- Despite charting symptoms indicating a decline during this eight-day period, nursing staff failed to contact Mr. B.'s doctor. Staff also failed to call the doctor when Mr. B.'s family requested on two separate occasions that the doctor see him and when Mr. B. himself asked to be sent to the hospital. Nursing home records on July 27 and July 30 also showed that the physical therapist "spoke with a director of nursing about the 'general apparent decline in the patient.'"
- By August 2, Mr. B. was in a semi-conscious state, unable to talk, bleeding from the rectum, spiking a temperature and aspirating*. At that point, staff contacted Mr. B.'s attending physician, who ordered immediate tests.
- Lab tests obtained that day revealed that Mr. B.'s sodium level was so high that it was life-threatening. Upon seeing these results, Mr. B.'s doctor ordered that he be sent to the hospital immediately.
- At the hospital, Mr. B. was found to be severely dehydrated and to have pneumonia.
- Six experts testified at trial that Mr. B. had one of the highest sodium levels they had ever seen.
- By the time Mr. B. was treated for dehydration, it was too late. The severe dehydration and high sodium levels Mr. B. experienced had created such an imbalance in Mr. B.'s electrolytes that his brain was poisoned.
- Mr. B. was not able to recover. He was placed in hospice care and was unconscious most of the next month. However, shortly before his death, he opened his eyes and began talking to his relatives. He spoke his last words to his six-year-old granddaughter to whom he said, "Don't forget me." He died on September 3, 2001 of brain poisoning, diagnosed as toxic metabolic encephalopathy*.

The human cost of neglect:

- Severe dehydration
- Severe hypernatremia*
- Pneumonia
- Toxic metabolic encephalopathy
- Death

The financial cost of neglect:

- $132,157.17

ANY CONSEQUENCES TO THE FACILITY?

- Did the survey agency fine the facility for this neglect?.....No
- What was the amount of fine actually paid?.....$0
- Did the survey agency deny payments for all new admissions of residents on Medicare/Medicaid?.....No
- Did the survey agency place the facility on state monitoring status?.....No
- Was the facility's license placed on probationary status or revoked for this neglect?.....No
- Was this neglect criminally prosecuted?.....No

35.

Resident: Eloise K.
State: Wisconsin
Type of Facility: Nursing Home
Residency: 8/4/99 – 5/21/00

THE BEFORE PICTURE

An introduction to Eloise K.

- Age: 79
- Life's occupation: Antique business owner
- 1 daughter, 2 granddaughters, 2 great grandchildren
- Was her daughter's best friend
- Great sense of humor

Facility assessment of Eloise K. upon admission:

- Recovering from a brain aneurysm*
- Had a urinary catheter*
- No urinary tract infection
- Received nutrition via a feeding tube
- Had a tracheostomy tube*
- Totally dependent on staff for help with bathing, dressing/grooming, and transferring*
- No end-stage disease

A PROFILE IN NEGLECT

How Eloise K. was neglected:

- After being admitted to the facility on August 4, 1999, Mrs. K. had recurrent urinary tract infections during her nursing home stay.
- In April 2000, upon her development of another urinary tract infection, Mrs. K.'s doctor ordered a seven-day course of antibiotics, which she began on April 24, 2000. The doctor also ordered a urine culture to be taken two days after completion of the antibiotics to recheck for infection.
- After the antibiotic treatment was finished, nursing staff failed to carry out the doctor's order for the follow-up urine culture.
- According to expert testimony from a physician, Mrs. K. continued to have an infection "which would have been identified if they would have done the follow-up urine culture."
- On May 19, 2000, Mrs. K. vomited three times. She was also noted to have problems with impaction of her bowels on that day, and nursing staff removed a large amount of stool.

- On May 20, nurses documented that Mrs. K.'s catheter was plugged and that, after it was removed, there were green, cloudy, thick secretions with foul-smelling pus noted at the opening to the bladder. Later that same morning, Mrs. K. experienced projectile vomiting and developed respiratory problems. She was sent to the emergency room where vomit had to be suctioned from her throat before a tube could be inserted into her trachea to help her breathe.
- Mrs. K. died on May 21, 2000 of aspiration pneumonia* as a consequence of urosepsis*.
- A physician expert testified that if a follow-up urine culture had showed infection and Mrs. K. had been treated with antibiotics, she "wouldn't have developed the urosepsis, wouldn't have developed the ileus*, wouldn't have developed the aspiration*." In other words, Mrs. K. would not have died.

The human cost of neglect:

- Urosepsis*
- Aspiration pneumonia
- Death

The financial cost of neglect:

- $18,621.28 (hospital expenses, ambulance fees)

ANY CONSEQUENCES TO THE FACILITY?

- Did the survey agency fine the facility for this neglect?.....**No**
- What was the amount of fine actually paid? **$0**
- Did the survey agency deny payments for all new admissions of residents on Medicare/Medicaid? .....**No**
- Did the survey agency place the facility on state monitoring status?.....**No**
- Was the facility's license placed on probationary status or revoked for this neglect?.....**No**
- Was this neglect criminally prosecuted?.....**No**

36.

Resident: Glen M.
State: Wisconsin
Type of Facility: Nursing Home
Residency: 9/12/00 – 9/19/00

THE BEFORE PICTURE

An introduction to Glen M.

- Age: 82
- Life's occupation: Manager, life insurance company
- 5 children, 17 grandchildren, 3 great grandchildren
- Devoted family man
- Active volunteer in the community
- Loved flower gardening and working in the yard

Facility assessment of Glen M. upon admission:

- Admitted for rehabilitation following surgery for rupture of left quadriceps tendon
- Right arm amputated below elbow from childhood accident
- Parkinson's Disease
- Diabetes
- At risk for malnutrition
- Depression

A PROFILE IN NEGLECT

How Glen M. was neglected:

- Upon his admission to the nursing home on September 12, 2000, Mr. M.'s orthopedic surgeon issued written orders to the nursing staff that Mr. M. was to wear a brace on his left leg at all times, except when bathing, and that a dry dressing should be applied to the surgical site, which was located in the area around Mr. M.'s left knee.
- Both the facility Administrator and Director of Nursing testified that the surgical site of a resident such as Mr. M. needs to be observed and monitored for signs of infection at least daily.
- A nurse noted that Mr. M.'s surgical site was slightly red on September 12.
- According to the nursing home records, nursing staff failed to inspect or assess Mr. M.'s surgical site from September 13 until the morning of September 18.
- At a physical therapy session on September 18, a physical therapy aide removed Mr. M.'s brace in order to reposition it because the brace was not properly in place. She observed drainage on the bandage underneath and, upon taking it off, noted drainage around the surgical site, redness and warmth from above the knee to the hip/groin area, and seepage along the groin and side of the knee. A nurse contacted the office of the orthopedic surgeon, but did not talk to the surgeon. Mr. M.'s routine orthopedic appointment was moved to the next day.

- On September 19, the orthopedic surgeon found that Mr. M.'s leg was red and swollen from mid-thigh to his calf with foul-smelling pus draining from the surgical site. According to Mr. M.'s daughter, who was present during the examination, pus-like substance sprayed across the room when the doctor applied pressure to the knee in order to extract pus from the wound. The nurse who was present was so distressed that she began crying.
- The surgeon immediately admitted Mr. M. to the hospital where he performed emergency surgery on Mr. M.'s leg. Mr. M.'s infection was so severe that he was in septic shock*, his mental status was altered, and he was barely alert.
- Treatment of Mr. M.'s knee required hospitalization to irrigate* the wound and to surgically debride* it three times.
- Mr. M. was discharged to a different nursing home on October 3, 2000, where he continued to suffer severe left leg pain. In order to try to save Mr. M.'s leg and prevent him from losing yet another limb, nursing staff repeatedly extracted pus from the wound. One of the nurses testified that Mr. M.'s pain during these procedures was "excruciating."
- Although Mr. M.'s potential for rehabilitation was assessed as good upon his admission to the first nursing home and the plan was for him to return home, the severity of the infection of his surgical site set off a series of events which resulted in Mr. M.'s increased disability. Mr. M.'s tendon was destroyed, his knee could not be reconnected, and he could no longer move his left leg. His doctor told him in December 2000 that there would be ongoing chronic pain, continued swelling and possibly a continued infection.
- In addition to daily pain, Mr. M. suffered emotionally as well. Mr. M. was keenly aware of his loss of independence, and this loss increased his depression. He told his doctor, "The only thing I look forward to are visits from my family."

The human cost of neglect:

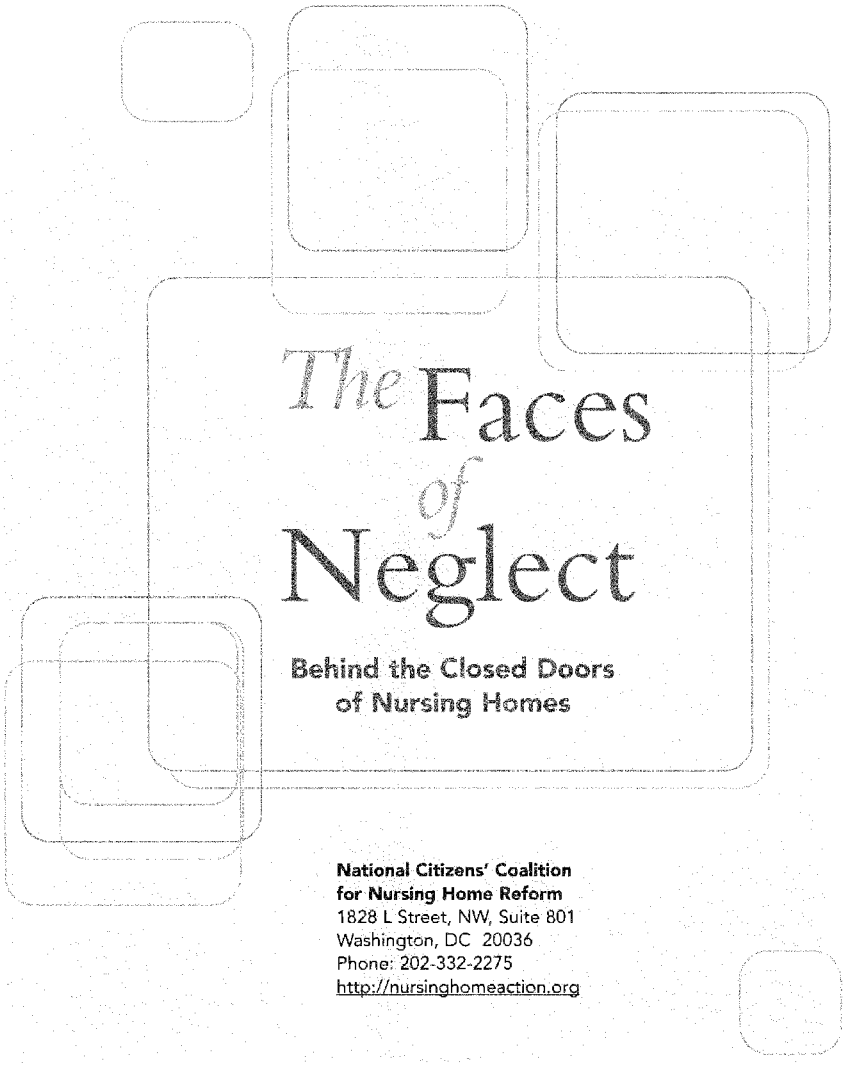
- Infection and septic shock
- Excruciating and then chronic pain
- Total disability
- Severe emotional pain and increased depression

The financial cost of neglect:

- $197,566.33 (hospital expenses, subsequent nursing home care)

ANY CONSEQUENCES TO THE FACILITY?

- Did the survey agency fine the facility for this neglect? ..... **Yes**
- What was the amount of fine actually paid? ..... **$3,718 (reduced from $5,720)**
- Did the survey agency deny payments for all new admissions of residents on Medicare/Medicaid? ..... **No**
- Did the survey agency place the facility on state monitoring status? ..... **No**
- Was the facility's license placed on probationary status or revoked for this neglect? ..... **No**
- Was this neglect criminally prosecuted? ..... **No**



National Citizens' Coalition for Nursing Home Reform
1828 L Street, NW, Suite 801
Washington, DC 20036
Phone: 202-332-2275
http://nursinghomeaction.org

Resources

Abuse & Neglect

The Times-Picayune. Louisiana. Special Report. *State of Neglect.* April 17-21, 2005.
http://www.nola.com/speced/nursinghomes/

Overview: This powerful five-part series closely examines the failures of many Louisiana nursing homes to provide adequate care for their residents. The series emphasizes Louisiana's minimal penalties and lack of enforcement for nursing homes that endanger residents' health and safety. It further highlights weaknesses in the survey process; inadequate staffing as a precursor to inadequate care; and the nursing home industry's financial and political clout in the Louisiana Statehouse that have defeated efforts to reform the system.

Administration on Aging. *2004 National Ombudsman Reporting System (NORS) Data Tables.*
http://www.aoa.gov/prof/aoaprog/elder_rights/LTCombudsman/National_and_State_Data/2004nors/2004nors.asp

Overview: This report provides 2004 data from the long-term care ombudsman program – a federally mandated program that advocates on behalf of residents of long term care facilities. In 2004, ombudsmen handled more than 220,000 complaints, many of them related to resident care and resident rights.

U.S. Congress. Senate. Finance Committee. *Nursing Home Quality Revisited: The Good, the Bad and the Ugly: Hearing before the Committee on Finance.* 108th Cong., 1st sess., July 17, 2003.
http://finance.senate.gov/hearings/91231.pdf

Overview: This hearing examined the quality of nursing home care nationwide. An Illinois daughter testified that her mother died after four days in a nursing home from a dirty, clogged tracheotomy tube and the nursing home's failure to administer prescribed medications. A West Virginia daughter testified that her mother, who suffered from Alzheimer's disease, was found dead in her nursing home with a shower hose around her neck. Both daughters stated that subsequent investigations yielded no action against the facilities. The acting Inspector General of the Department of Health and Human Services testified that federal inspectors who conducted comparative surveys of nursing homes in 2002 consistently found more deficiencies and more serious deficiencies than states found when surveying the same facilities.

St. Louis Post-Dispatch. Missouri. Special Reports. *Neglected to Death.* October 12-19, 2002.
http://www.stltoday.com/stltoday/news/special/neglected.nsf/front?openview&count%20t=2000#

Overview: This week-long special report highlighted the prevalence of neglect in Missouri nursing homes; described how inadequate staffing leads to poor care; showed how victims of abuse and neglect rarely received justice; illustrated the challenges and frustrations of regulators as they try to enforce quality standards; recognized attempts by legislators to seek legislative solutions; examined innovative approaches to nursing home care; and described the plight of one family trying to care for their ailing mother. The report included opinion pieces and reactions from government officials, advocacy groups, and more.

U.S Congress. Senate. Special Committee on Aging. *Safeguarding Our Seniors: Protecting the Elderly from Physical and Sexual Abuse in Nursing Homes: Hearing before the Special Committee on Aging.* 107th Cong., 2nd sess., March 4, 2002. http://aging.senate.gov/public/events/030402.html

Overview: This powerful hearing featured the testimony of two family members and an attorney about the horrifying beating-related deaths of two frail elderly women; the rape and resulting pregnancy of a younger woman; and the failure of state health departments and law enforcement officials to address the crimes.

U.S. General Accounting Office (GAO). *More Can be Done to Protect Residents from Abuse.* GAO-02-312. March 2002. http://www.gao.gov/new.items/d02312.pdf

Overview: This report found that over 30 percent of the nation's nursing homes had received citations for causing actual harm to residents or placing them in immediate jeopardy. The report further found that abuse allegations are not reported quickly; few abuse allegations are prosecuted; and safeguards to protect residents from abusive individuals are inadequate.

Assisted Living

National Senior Citizens' Law Center. *Critical Issues in Assisted Living: Who's In, Who's Out, and Who's Providing the Care.* May 2005. http://www.nsclc.org/news/05/05/AL report.htm

Overview: This report is based on a review of the laws and regulations of all 50 states and the District of Columbia applying to assisted living facilities. It examines the balance between provider flexibility and resident protection. The report highlights how state assisted living laws are, or are not, addressing critical issues in assisted living such as definitions of levels of care, protections for involuntary discharges, and staff training and makeup. The report discusses the pros, cons, and implications of various state approaches.

USA Today. *Assisted Living: When Caregivers Fail.* May 26-June 1, 2004. http://www.usatoday.com/money/industries/health/2004-06-01-assisted-living_x.htm

Overview: This week-long series, based on an investigation of inspection records of more than 5,000 assisted living facilities, found "a pattern of mistakes and violations that lead to scores of injuries and occasional deaths among the estimated 1 million elderly residents of assisted living facilities." The series emphasized the failure of state government to effectively regulate assisted living facilities and stressed the minimal training required for assisted living nurse aides.

The Washington Post.Virginia. Special Report. *A Dangerous Place.* May 23-27, 2004. http://www.washingtonpost.com/wp-dyn/metro/va/homes/

Overview: This 18-month investigation found "a troubled and worsening record of care" in Virginia's assisted living facilities, "including avoidable injuries and deaths, and a system of state oversight that often failed to identify or correct problems." The investigation concluded that at least 51 deaths were attributable to neglect and that in more than 135 other cases "residents suffered sexual assaults, physical abuse or serious injuries, including head wounds, broken bones, burns and life-threatening medication errors." In fact, in an eight-year period, about 4,400 residents had been "victims of abuse, neglect or exploitation."

Enforcement

U.S. Government Accountability Office (GAO). Report to Congressional Requesters. *Nursing Homes: Despite Increased Oversight, Challenges Remain in Ensuring High-Quality Care and Resident Safety.* GAO-06-117. December, 2005. http://www.gao.gov/new.items/d06117.pdf

Overview: This report found that the decline in the proportion of nursing homes with serious quality problems in the Centers for Medicare and Medicaid Services' (CMS's) nursing home survey data masks two important problems: inconsistency among state surveyors in conducting surveys and understatement by state surveyors of deficiencies that caused harm or immediate jeopardy to residents. In five large states with significant declines in serious deficiencies, federal surveyors concluded that state surveyors had missed serious deficiencies in 8 percent to 33 percent of facilities where federal inspectors conducted comparative surveys. This analysis is consistent with GAO's finding in July 2003 that there was considerable understatement of quality-of-care problems, such as serious, avoidable pressure sores.

Morain, Dan. "Nursing Home Scrutiny Lagging. Enforcement of tough laws is on the wane despite increase in complaints about care. State budget cuts have left too few inspectors." *LA Times.* July 31, 2005.

Overview: This article highlights the failures of California's state health department to enforce state nursing home laws. The article contends that state inspectors focus on enforcing less stringent federal standards rather than tougher state laws in order to protect federal funding. Advocates point out that that federal sanctions are rarely carried out and therefore California nursing homes often go unpunished for noncompliance.

U.S. Office of Inspector General (OIG). Department of Health and Human Services (HHS), *Nursing Home Enforcement: Collection of Civil Money Penalties.* OEI-06-03-00420. July 2005. http://oig.hhs.gov/oei/reports/oei-06-03-00420.pdf

Overview: Using data from nursing home enforcement cases initiated in 2002, this report examined the extent to which the Centers for Medicare & Medicaid Services collected civil monetary penalties (CMPs) and followed up with required collection procedures. The report found that, as of March 2004, four percent of the CMPs imposed in 2002 were not fully collected. An additional eight percent were past due by more than 30 days before they were collected. The report further showed that in 94 percent of past-due CMPs, CMS did not take all the required actions to ensure payment. Furthermore, responsibility for CMP collection is unclear within the agency, and the database used to track CMP collections is fraught with errors and incomplete information.

U.S. Office of Inspector General (OIG). Department of Health and Human Services (HHS), *Nursing Home Enforcement: The Use of Civil Money Penalties.* OEI-06-02-00720. April 2005. http://oig.hhs.gov/oei/reports/oei-06-02-00720.pdf

Overview: This report found that in 2000-2001 the Centers for Medicare & Medicaid Services used civil monetary penalties (CMPs) in 51 percent of their enforcement cases. However, the report shows that 70 percent of those cases had their fine reduced prior to their request for payment. Facilities receive a 35 percent reduction simply for waiving their right to appeal. As of December 2002, 14 percent of imposed CMPs remained uncollected and eight percent were not yet due because of appeals and/or

bankruptcies. The report found that cases with no appeal take over six months to collect while appealed cases take significantly longer. According to the report, CMS also tends to impose the lower end of allowed fines rather than the maximum amount.

U.S. General Accounting Office (GAO). Report to Congressional Requesters. *Nursing Home Quality: Prevalence of Serious Problems, While Declining, Reinforces Importance of Enhanced Oversight.* GAO-03-561. July 15, 2003. http://www.gao.gov/new.items/d03561.pdf

Overview: This report found an unacceptably high number of nursing homes with serious quality problems and identified weaknesses in state survey, complaint and enforcement processes. Recommendations included strengthening the nursing home survey process, ensuring that state-surveys and complaint investigations sufficiently assess quality of care problems, and improving CMS oversight of state survey activities.

U.S. Office of Inspector General (OIG). Department of Health and Human Services (HHS), *Nursing Home Deficiency Trends and Survey and Certification Process Consistency.* March 2003. http://oig.hhs.gov/oei/reports/oei-02-01-00600.pdf

Overview: This report described trends in nursing home deficiencies and examined the inconsistencies among states in implementing the federally required survey and certification process. Important findings include an increase in the number of nursing home deficiencies from 1998-2001 and discrepancies in how states determine the number and type of deficiencies. The OIG concluded that the rise in the number of deficiencies was cause for concern.

U.S. General Accounting Office (GAO). Report to Congressional Requesters. *Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards.* GAO/HEHS-99-46. March 18, 1999. http://www.gao.gov/archive/1999/he99046.pdf

Overview: This report showed that nursing homes nationwide were consistently not held accountable for noncompliance with federal quality standards. The report identified four obstacles to effective enforcement: (1) backlog of civil monetary penalties; (2) weaknesses in deterrent effect of withholding federal funds; (3) failure to require states to report deficiencies that contributed to a resident's death; and (4) the weak information management system of the Health Care Financing Administration (HCFA), now known as CMS.

U.S. General Accounting Office (GAO). Report to the Special Committee on Aging. *California Nursing Homes: Care Problems Persist Despite Federal and State Oversight.* GAO/HEHS-98-202. July 28, 1998. http://www.gao.gov/archive/1998/he98202.pdf

Overview: This report found weak federal and state oversight of California nursing homes. According to the study, one in three California nursing homes was cited for serious or potentially life-threatening deficiencies. The severity of care problems was often understated; facilities could predict when their annual survey would occur; facility documentation was often incomplete or inaccurate; and state surveyors frequently missed serious deficiencies, such as significant weight loss or failure to prevent bed sores. Finally, the report showed that when the state did identify a serious care problem, the federal overseeing agency did not ensure that the deficiency was corrected and remained corrected.

Staffing

Harrington, C., Carrillo, H., Crawford, C. *Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1998 through 2004.* Department of Social and Behavioral Sciences, University of California, San Francisco, CA, August 2005. http://www.nccnhr.org/public/245_1267_11874.cfm

Overview: This book presents calendar year data from 1998 through 2004 on nursing facilities, staffing, resident characteristics, and surveyor reports of quality deficiencies by state. Data in the report show that the average number of registered nurse hours per resident day declined by 25 percent (from 0.8 hours to 0.6 hours), although there was an increase in nursing assistant hours. In addition, the data reveal that the average number of deficiencies increased by 43 percent, and quality of care is the second most common violation of federal regulation, increasing from 17 percent to 26 percent of all U.S. nursing homes.

American Health Care Association. Health Services Research and Evaluation. *Results of the 2002 AHCA Survey of Nursing Staff Vacancy and Turnover in Nursing Homes.* February 12, 2003.

Overview: This report presents the results of a survey completed by almost 40 percent of U.S. nursing homes. The data collected as of June 30, 2002 found that nursing staff turnover was consistently high across the country. Annual turnover for staff registered nurses, licensed practical nurses and directors of nursing stood at about 50 percent, while turnover for certified nursing assistants was estimated at an average of 71 percent, with many states exceeding that rate.

U.S. Office of Inspector General (OIG). Department of Health & Human Services (HHS). *Nursing Home Medical Directors Survey.* February 2003. http://oig.hhs.gov/oei/reports/oei-06-99-00300.pdf

Overview: This government survey of nursing home medical directors reported that 86 percent of doctors charged with overseeing medical care in nursing homes spend eight hours a week or less in the facility. Sixty-two percent of the medical directors reported that they visited the facility once a week or less.

U.S. Department of Health & Human Services. Centers for Medicare & Medicaid Services (CMS). *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes Phase II Final Report.* December 2001. http://www.cms.hhs.gov/medicaid/reports/rp1201home.asp

Overview: This report to Congress concluded that below nurse staffing levels identified by researchers, "there appears to be little facilities can do to mitigate quality problems;" and moreover, that more than 90 percent of nursing homes do not have enough licensed nurses and nurse aides to avoid serious health and safety problems or to provide basic care services.

U.S. Congress. Senate. Special Committee on Aging. *Nursing Home Residents: Short-changed by Staff Shortages, Part II: Hearing before the Special Committee on Aging.* 106th Cong., 2nd sess., July 27, 2000. http://aging.senate.gov/public/events/hr55.htm

Overview: This hearing discussed the findings of a study conducted by the Health Care Financing Administration (HCFA) that concluded that there is a strong connection between staffing levels and the quality of care provided in nursing homes. The administrator of HCFA testified that 56 percent of all nursing homes were below the preferred minimum level for total licensed staff. One researcher who participated in the study concluded that there are identifiable staffing levels below which resident care is compromised, and another researcher concluded that 2.0 hours of nurse aide time per resident per day is too little to provide adequate care.

Harrington C., Kovner C., Mezey M., Kayser-Jones J., Burger S., Mohler M., Burke R., and Zimmerman D. "Experts recommend minimum nurse staffing standards for nursing facilities in the United States." *The Gerontologist*. 2000. Vol. 40, Issue 1, pp. 5-16.

Overview: This article strongly encourages legislators and/or regulators to adopt a federal minimum staffing standard for nursing homes nationwide. Recommendations included in the article closely resemble the national staffing standards proposed by NCCNHR in 1998. Specifically, the experts call for a minimum of 4.13 hours of direct nursing care per resident per day. On the day shift, 1 Licensed Practical Nurse or Registered Nurse (LPN/RN) for every 15 residents and 1 nursing assistant (NA) for every 5 residents. On the evening shift, 1 LPN/RN for every 20 residents and 1 NA for every 10 residents. And, on the night shift, 1 LPN/RN for every 30 residents and 1 NA for every 15 residents.

U.S. Congress. Senate. Special Committee on Aging. *Nursing Home Residents: Short-changed by Staff Shortages: Hearing before the Special Committee on Aging*. 106th Cong., 1st sess., November 13, 1999. http://aging.senate.gov/public/events/fr11.htm

Overview: This hearing examined the relationship between staff levels and quality care in nursing homes. One mother of a nursing home resident emphasized the seriousness of understaffing by highlighting several instances, often dangerous, when her daughter's call light went unanswered. One certified nursing assistant (CNA) described her unrealistic work load caring for 15 residents on her 3:00 p.m. – 11:00 p.m. shift. A state ombudsman urged Congress to require and adequately enforce national minimum standards for nursing home staff. Industry representatives testified that "quantity is not quality" and opposed a national minimum staffing standard.

State Specific Reports

U.S. Congress. House of Representatives. Committee on Government Reform. Minority Staff. Special Investigations Division. *Nursing Home Conditions in Arkansas: Many Nursing Homes Fail to meet Federal Standards for Adequate Care*. November 6, 2003. http://www.democrats.reform.house.gov/Documents/20040624112120-66634.pdf

Overview: More than 90 percent of Arkansas's 245 nursing homes that accepted federal funding were in violation of federal health standards. Over one-third of these facilities had deficiencies which caused actual harm to residents or put them at risk of death or serious injury. The report further showed that most Arkansas nursing homes do not provide adequate staffing.

U.S. Congress. House of Representatives. Committee on Government Reform. Minority Staff. Special Investigations Division. *Nursing Home Conditions in Los Angeles County: Many Nursing Homes Fail to Meet Federal Standards for Adequate Care*. February 4, 2003. http://www.democrats.reform.house.gov/Documents/20040624114555-60143.pdf

Overview: Ninety-one percent of federally funded nursing homes in Los Angeles County, California violated federal health standards. The 2003 report was a follow-up to a similar 1999 report that showed most facilities in Los Angeles County failed to meet federal health and safety standards. The report concluded that most facilities in Los Angeles County continued to provide substandard care.

U.S. Congress. House of Representatives. Committee on Government Reform. Minority Staff. Special Investigations Division. *Nursing Home Conditions in Texas: Many Nursing Homes Fail to meet Federal Standards for Adequate Care*. October 28, 2002.

http://www.democrats.reform.house.gov/Documents/20040830112134-57472.pdf

Overview: Eighty-six percent of federally funded Texas nursing homes violated national health and safety standards, and over one-third of all facilities had deficiencies that caused actual harm to residents or put them at risk of death or serious injury. Finally, the report found that over 90 percent of nursing homes did not meet recommended staffing levels.

U.S. Congress. House of Representatives. Committee on Government Reform. Minority Staff. Special Investigations Division. *Nursing Home Conditions in the 13th Congressional District of Pennsylvania: Many Nursing Homes Fail to meet Federal Standards for Adequate Care.* July 23, 2001. http://www.democrats.reform.house.gov/Documents/20040830114240-99423.pdf

Overview: More than 70 percent of federally funded nursing homes in the 13th district of Pennsylvania violated federal health and safety standards in inspections. Additionally, more than half of those facilities had deficiencies that caused actual harm to residents or put them at risk of death or serious injury.

Medical Malpractice and Nursing Homes

Stevenson, David G., Ph.D. Testimony before the U.S. Senate Special Committee on Aging, *Medical Liability in Long Term Care: Is Escalating Litigation A Threat to Quality and Access?* 108th Cong., July 15, 2004. http://aging.senate.gov/public/_files/hr127ds.pdf

Overview: Stevenson urged lawmakers to take into consideration "the distinct features of nursing home litigation" when considering tort reform, including the fact that since "few elderly have ongoing sources of income that would be diminished by physical injury," noneconomic damages account for about 80 percent of nursing home residents' compensation. "Insufficient sensitivity" to the special distinctions of nursing home cases, he testified, including the fact that half of such cases involve deaths, would mean that the ability of negligently-injured residents and their families to "obtain reasonable compensation for worthy claims would be inappropriately blocked."

Studdert, David M., LLB, SCD, MPH, Stevenson, David G., PhD. "Nursing Home Litigation and Tort Reform: A Case for Exceptionalism." *The Gerontologist.* Vol. 44, No. 5 (2004): 588–595.

Overview: This article cautions legislators against a one-size-fits-all policy fix to address the alleged litigation crisis in nursing homes and acute care settings. The authors emphasize the intrinsic differences in nursing home litigation such as the increased significance of non-economic damages, the pervasiveness of punitive damages, and the unique nature of injuries in the long-term care setting.

Edelman, Toby S., Esq., Center for Medicare Advocacy, Inc. *Tort Reform and Nursing Homes.* April 2003. http://medicareadvocacy.org/Media_PR_TortReform.htm

Overview: This study concluded that nursing home malpractice lawsuits are not frivolous; malpractice cases occur when residents have been seriously injured or died. Major findings of the report include evidence that: (1) tort litigation is not the cause of increasing insurance premiums; (2) there has not been a dramatic increase in tort litigation; and (3) actual pay-outs or settlements rarely equal the large jury verdicts reported in the media. Edelman concludes that limiting non-economic damages in tort reform litigation to $250,000 would allow the multi-billion dollar nursing home industry to provide substandard care with no fear of significant financial retribution.

Glossary

*Glossary terms used in the case descriptions are marked with an **

This glossary will help the reader better understand the experiences of the residents whose stories are told in this document.

ACIDOSIS: An abnormal condition of the blood caused by an accumulation of acid or a decrease in the alkaline reserve content in the blood and the body tissues.

ACUTE RENAL FAILURE: A sudden cessation of kidney function.

ANEURYSM: A sac formed by the dilatation, or stretching, of the wall of an artery or vein.

ASPIRATE: To suck in or inhale into the lungs matter such as food, liquid or gastric contents. vt. -rated.

ASPIRATION: The inhalation into the lungs of food, liquid, or gastric contents.

ASPIRATION PNEUMONIA: A pneumonia resulting from the aspiration, or inhalation, into the lungs of food, liquid, or gastric contents. Some causal or contributing factors to aspiration pneumonia are disorders interfering with swallowing such as a stroke, unconscious or semi-conscious individuals, old age, and dental problems.

ATRIAL FIBRILLATION: Very rapid irregular contractions of the upper chambers of the heart. Atrial fibrillation increases dramatically the incidence of blood clots and strokes, especially in the elderly.

AVULSIONS: A tearing away of a body part accidentally or surgically.

BETADINE: A preparation of povidone-iodine that destroys or delays new tissue growth when applied to healing wounds.

CARCINOMA: A malignant tumor. Commonly referred to as cancer.

CARE PLAN: A written plan for meeting the medical, physical, psychosocial, emotional, and spiritual needs of a nursing home resident. This care plan is prepared by an interdisciplinary team of staff members working with the resident (when possible), the resident's family (or representative), and the resident's doctor. The care plan must be updated when there is any change of condition, at least every quarter, and annually.

CAROTID: The two main arteries situated on each side of the front of the neck that supply blood to the head.

CATHETERIZE: The insertion of a catheter, or tube, into a body part such as the heart or bladder. The most common catheterization is the insertion of a catheter into the bladder for the removal of urine.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE: C.O.P.D. refers to a group of chronic, irreversible disorders that damage the lungs and over time cause increasing breathing difficulty. Emphysema and chronic bronchitis are the two most common forms of C.O.P.D. Cigarette smoking is implicated in 80% of all cases.

COCCYX: A group of four small fused bones coming to a point at the end of the spine. The coccyx is also called the tailbone.

COLOSTOMY BAG: A bag that is kept in position next to the abdomen to collect feces when the intestine is connected surgically to the abdominal wall to form an artificial anus.

CONGESTIVE HEART FAILURE: Heart failure in which the heart is unable to maintain an adequate circulation of blood to the tissues of the body or to pump out the blood that the veins are returning to the heart by the venous circulation. Congestive heart failure is a chronic condition that can lead to death.

CONTRACTURES: A permanent shortening of a muscle or a tendon, which produces a deformity or distortion of the arm or leg. Contractures are usually preventable if muscles are diligently stretched and exercised.

CYANOTIC: A bluish or purplish discoloration of the skin and mucous membranes due to a lack of oxygen in the blood.

DARVOCET: An analgesic used for mild to moderate pain relief that combines propoxyphene hydrochloride and acetaminophen.

DEBRIDEMENT: The surgical or chemical removal of damaged or diseased tissue that may be impeding healing. Debridement is one of the treatments for severe pressure sores. - debride vt. - brided, — briding.

DEMEROL: A narcotic analgesic used for moderate to severe pain relief.

DIABETIC KETOACIDOSIS: Occurs when insulin levels are far lower than the level the body needs and causes the blood to become acidic and the body to be dangerously dehydrated. This is a potentially fatal complication unless treated promptly.

DIURETIC: A medication given to increase the excretion of water from the body when there is a need to rid the body of excess fluids.

ELECTROLYTE IMBALANCE: An inappropriate level of blood electrolytes such as sodium, potassium, or chloride, in the bloodstream. Abnormal levels of electrolytes affect the flow of nutrients into cells and waste products out of cells.

ELOPEMENT: The leaving of a facility by a resident without the knowledge of the staff. Elopement is of special concern when the resident has dementia and leaving the facility puts the resident at high risk for harm.

ESCHAR: A scab-like black crust covering some pressure sores.

FIBULA: The smaller of the two leg bones below the knee.

FLAP SURGERY: Surgery in which a piece of tissue is partly severed from its origin in order to use the skin for a surgical graft. By leaving part of the skin attached to its origin, the blood supply is maintained, and the possibility of a successful graft is increased. Flap surgery can be used for the attempted repair of severe pressure sores.

GANGRENOUS: The death of tissue, in an area such as the foot or a pressure sore, which has been deprived of an adequate oxygen supply.

HYPERNATREMIA: An abnormal elevation of the blood sodium concentration. Normal blood sodium should be 136 to 142 milliequivalents per liter. Excessively high blood sodium can manifest as a decreased level of consciousness or a change in mental status.

HYPOTHERMIA: A below normal body temperature (<94 degrees) that leads to the elder usually being in critical condition. The mortality rate for hypothermia in the elderly is approximately 50%.

HYPOTHYROIDISM: A condition caused by the failure of the thyroid gland to produce adequate hormones.

ILEUS: An obstruction of the intestine. A condition that is commonly accompanied by a painful distended abdomen, dehydration, toxemia, and vomiting of dark vomitus or fecal matter which results when intestinal contents back up because peristalsis, the muscular movements that move food through the intestines, fails.

IRRIGATION: To wash or cleanse an area or tube with a stream of fluid in order to remove debris.

MECHANICAL ASPHYXIA: Suffocation, or a lack of oxygen, not caused by a biological or chemical problem.

METABOLIC ACIDOSIS: A metabolic derangement of the acid-base balance where the blood Ph is abnormally low.

MRSA: Methacillin Resistant Staphylococcus Aureus. Includes several strains of Staphylococcus Aureus that are not killed by the usual antibiotics and can cause very severe infections in wounds or surgical sites.

MYELITIS: Inflammation of the spinal cord or of the bone marrow.

NECROSIS: The death of living tissue. The death of the tissue is frequently caused by pressure on the skin, especially at bony prominences, which can cause the loss of blood supply and oxygen to that area.

NECROTIC TISSUE: Dead tissue.

OSTEOMYELITIS: An infectious inflammatory disease of the bone that is often bacterial in origin. Osteomyelitis is marked by the local death of and the separation of tissue.

PARENTERAL: The administration of a drug or a solution by a route other than the intestines, such as in a vein, muscle, or under the skin.

PERIODONTAL DISEASE: A disease of the tissue surrounding a tooth.

PERIPHERAL VASCULAR DISEASE: A disease of the blood vessels affecting especially the blood vessels of the extremities (arms and legs).

PERITONEUM: The lining of the abdominal cavity that surrounds the organs in the abdomen.

PERITONITIS: Inflammation of the peritoneum.

PNEUMONIA: A disease of the lungs, usually caused by infection, which can involve a fever, chills, difficulty breathing, and a cough.

PRESSURE SORE: A red area, sore, or ulceration on an area of skin that has been deprived of an adequate blood supply by prolonged pressure on that area. Usually occurs over a bony prominence. Other contributing factors to a pressure sore are lying in a wet environment, repeated irritation of the skin caused by traction or friction, and inadequate nutrition and hydration. The pressure sore is "staged" based on the amount of damage to the tissue. Charting of a pressure sore in a facility should include the stage, size in centimeters, a description of any drainage, if there is an odor, any treatment of the area, and any improvement or deterioration of the pressure sore. The stages of pressure sores are:

* Stage I: Skin reddened or purplish. Skin not broken.
* Stage II: Blister or skin broken. Dermis (top layer) and epidermis (second layer) of skin involved.
* Stage III: Deep crater in skin. Sore has damaged the fatty tissue or third layer of skin.
* Stage IV: Deep wound down to the muscle or bone.

A gloved hand can be an easy way to estimate the size of the pressure sore before a definitive measurement is made. The finger at the first joint is approximately 2 centimeters in an average person. Two "fingers" would be four cm., three fingers would be six cm., etc.

PSYCHOSOCIAL: Involving both psychological and social aspects of a person's life, such as age, education, marital status, and related aspects of a person's history.

PULMONARY DISEASE: Any disease of the lungs.

RANGE OF MOTION: The movement of the arms and legs through their normal range of movement in order to keep the muscles healthy.

RENAL: Pertaining to the kidneys.

RESTORATIVE CARE: Treatment provided in order to enable an individual to regain, as much as possible, their normal or healthy former state or lifestyle. Restorative care may involve walking, assistance with eating, talking, transferring from bed to chair, and other activities to attain maximum medical improvement.

SACRAL: Of, or in the region of, the sacrum.

SACRUM: The large flat bone, consisting of five fused vertebrae, which is near the end of the spine. The sacrum is directly connected with and forms a part of the pelvis.

SEPSIS: A toxic condition that results from the spread of bacteria, or their by-products, from the initial site of an infection.

SEPTICEMIA: The invasion of the bloodstream by virulent microorganisms from the initial point of an infection. Septicemia is accompanied by chills, fever, and inability to get out of bed and often by the formation of secondary abscesses in various organs. Also called blood poisoning.

SEPTIC SHOCK: Usually the result of a severe infection where bacteria and toxins in the blood stream cause a low blood pressure. This hypotension causes reduced blood and oxygen to tissues and organs and frequently causes them to malfunction. Septic shock is a life-threatening condition.

SKIN TEAR: A wound, usually on the arms or legs, where the skin has torn apart. Skin tears can be caused by friction, rough handling, falls, etc., and is seen most frequently in the frail elderly due to the fragile nature of the skin as the fat layer under the skin decreases with age.

STAGE I, II, III, OR IV: See "PRESSURE SORE."

TIBIA: The shinbone. The tibia is the larger of the two bones below the knee.

TOXIC METABOLIC ENCEPHALOPATHY: A disease where the brain is poisoned. This condition may be due to acidosis, liver failure, or uremia. Tremors that may accompany this condition are characterized by irregular flapping movements of the outstretched hands (as described in The Merck Manuel of Geriatrics, Third Edition).

TRACHEOSTOMY: The surgical formation of an opening into the trachea through the neck, especially to allow the passage of air into the lungs when an individual cannot breathe normally on his or her own.

TRACHEOSTOMY TUBE: The tube inserted, at the front of the neck, into the trachea to allow a person to breathe. Periodical suctioning or cleaning of the tube is essential in order to maintain an unobstructed airway.

TRANSFERRING: The movement of a person from one area to another such as from the bed to a wheelchair or from the wheelchair to a commode.

TUNNELING: The extension of a pressure sore under the edges of the skin.

UNDERMINING: The erosion or deterioration of the tissue under the edge of the skin of the pressure sore.

UREMIA: A severe toxic condition caused by the accumulation in the blood of particles that are normally eliminated in the urine. This condition usually occurs when there is severe kidney disease.

URINARY CATHETER: A small tube inserted into the urethra, the opening to the bladder, for the drainage of urine. The catheter is secured in place in the bladder by a small filled balloon.

UROSEPSIS: A toxic condition, which stems from a urinary tract infection, that causes the passing of urine by infiltration or effusion from a proper vessel or channel into surrounding tissues of the body.

VASCULAR DISEASE: A disease of the blood or lymph vessels of the body.

VASCULITIS: Inflammation of a blood or lymph vessel.